Urology of Indiana

New Patient Survey For Patients Visiting The Men's Health Center for Peyronie's

Clinic - (317) 564-5104 | Surgery Scheduling - (317) 807-0159

Name: _____

Age and Date of Birth: _____

1) How long have you noticed a curve with your erections? (Please write a number and circle years or months)

__ years / months

2) Do you remember a specific event that caused the curvature?

Yes / No

3) Does your curve become painful with erections?

Yes / No

4) In which direction does your penis curve? Up, down, left or right?

Direction: _____

5) A right angle (like the corner on the edge of a box) is considered 90 degrees. Something that is completely straight is considered 0 degrees. That being said, if you had to assign a number to your curvature, how many degrees would you estimate your curve is?

__ degrees

6) Can you feel a bump or knot where you curve is?

Yes / No

7) Does your erection get more narrow at your curve (like a belt has pulling things inward)?

Yes / No

Experiencing penile curvature without ED? Complete pages 1-3. Curvature and ED? Complete pages 1-7.

8) Do you feel like your erection get softer past your curve?

Yes / No

9) Are you able to have sex with your curve or is it too severe?

Yes / No

If yes, does your curve cause you or your partner pain or distress during intercourse?

Yes / No : If yes, please explain: _____

_____

10) Do you happen to bring any of your pictures of your curve with you today?

Yes / No

11) Have you sought treatment for this issue before?

Yes / No

If so, who did you see? What treatments did you try? Please explain:

_____

_____

12) Do you have any difficulties with your erections?

Yes / No

If yes, please answer this: If your penis was perfectly straight, would your current erectile function allow you to have satisfactory intercourse?

Yes / No

13) What do you do for a living? If retired, what did you use to do?

_____

SURGERY CANCELLATION & NO-SHOW POLICY

Thank you for choosing the **Men's Health Center at Urology of Indiana** for your care. As part of our standard intake process, we ask all patients to review and acknowledge the surgical scheduling policy below. **Signing this form does not mean that surgery has been recommended or that a procedure is being scheduled.** It simply ensures that you are aware of our office policy in the event that a surgical procedure is recommended and scheduled in the future.

We understand that unforeseen circumstances—such as family emergencies or personal obligations—may occasionally require a patient to cancel or reschedule a planned surgery. If that situation arises, we respectfully ask that you provide as much advance notice as possible so that we may offer the surgical time to another patient in need of care.

To schedule, cancel or reschedule a surgery, please contact our office at: **(317) 807-0159**

PLEASE REVIEW THE FOLLOWING POLICY:

1. All surgical cancellations or reschedule requests must be made at least four (4) weeks (28 calendar days) prior to the scheduled surgery date.
2. Any cancellation made less than four (4) weeks before the scheduled surgery date will be documented as a policy violation and may be subject to a **$500.00 cancellation fee**.
3. If you do not appear for your scheduled surgery without any prior notification, this will be documented as a "No-Show" and will also be subject to the **$500.00 fee**.
4. After a first policy violation, you will receive a phone call or written notice as a courtesy reminder of this policy. Please note that repeated violations may limit our ability to schedule future procedures on your behalf.
5. Chronic no-shows or repeated late cancellations may result in dismissal from the surgical schedule and potential termination of the patient–provider relationship.

By signing below, I acknowledge that I have read and understand the Urology of Indiana **"Surgery Cancellation & No-Show Policy."** I understand that this policy will apply if a surgical procedure is scheduled for me at any point during my care with this practice.

_____

Patient Name **Date of Birth** **Date**

_____

Patient Signature (or Parent/Guardian if Minor) **Date**

Thank you for your understanding and cooperation as we strive to best serve the needs of our patients.

If you answered 'Yes' to the first part of question #12, please complete the attached ED questionnaire. If you don't have erectile difficulties, you can return these pages.

New Patient ED Questionnaire

1) How long have you been having difficulties with your erections?

__ years / months

2) Have you sought treatment for this issue before?

Yes / No

If so, who did you see? List name or leave blank if you have not sought care for this issue before.

Name: _____

3) Have you tried any interventions to help improve your erections? (ex. oral medications, penile injections, vacuum device...)

Yes / No

If yes, please list: _____

4) Were these treatments effective when you first tried them? Circle yes or no. Please leave blank if you answered 'no' to the previous questions and have not tried anything to improve your erections yet.

Yes / No

5) Are any of these interventions still working for you currently? Why or why not?

Yes / No

Explain: _____

6) Would you say you have greatest difficulty with ACHIEVING an erection, MAINTAINING an erection, or BOTH?

Achieving / Maintaining / Both

7) If you had to rank the rigidity of your average erection (without medication) from 0-10 with 0 being no erection and 10 being the most rigid erection you've ever had, what ranking would you give?

___ (out of 10)

8) Is this erection sufficient for penetration?

Yes / No

9) Do you still experience erections in the middle of the night or when you wake up in the morning?

Yes / No

10) Do you currently use any tobacco or nicotine containing products? If yes, please list the product, the amount, and duration of use. (ex. Cigarettes, 1 pack per day for 20 years)

Yes / No

Product / amount / duration? _____

11) If do not currently use any tobacco or nicotine containing products, but used to, please list what you used to use, the amount, the duration, and when you stopped using. (ex. Cigarettes, 1 pack per day for 20 years, Quit 5 years ago)

Product / amount / duration? _____

12) How many alcoholic beverages do you think you have in an average week? (ex. 4 beers a week)

Amount: _____

13) Do you use any other substances that don't come from physician? (ex. marijuana)

Yes / No

If yes, please list: _____

14) Do you have diabetes?

Yes / No

If yes, please list medications you take for this and your most recent A1C level:

- _____
- _____

15) Do you have high blood pressure?

Yes / No

If yes, please list medications you take for this:

- _____

16) Do you have any history of heart disease, stroke, or other vascular disease?

Yes / No

If yes, please explain and list any medications you take for this. This should include any blood thinners like Plavix (clopidogrel), Xarelto (rivaroxaban), or Coumadin (warfarin):

- _____
- _____
- _____

17) Have you ever had your testosterone levels checked? If yes, how long ago and by whom? If yes, do you remember if the results were normal or not?

Yes / No

Explain: _____

18) Have you ever received radiation to your prostate or pelvis?

Yes / No

If yes, please explain: _____

19) Have you undergone prostate removal surgery to treat prostate cancer?

Yes / No

If yes, please explain: _____

20) Have you had any other surgeries in the pelvis or groin? (ex. hernia repair, bladder removal)

Yes / No

If yes, please explain: _____

21) Have you ever experienced difficulty with climaxing too early (also known as premature ejaculation)?

Yes / No