Urology of Indiana

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

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

Name: _____

Date of Birth: _____

1) As best as you can remember, in what year was your vasectomy?

- _____

2) Were there any complications with your vasectomy?

Yes / No

If yes, please explain: _____

3) How old are you?

- _____

4) What is your current partner's name, age, and date of birth (DOB)?

Partner's Name, Age, and DOB:_____

5) What best describes you and your partner's relationship? How long have you been together in this capacity? (ex. married for 3 years)

Relationship and duration: _____

6) How many times has your partner been pregnant, including with any prior relationships?

- _____

7) How many children does your partner have? How old is her youngest child?

- _____

Please complete all 4 pages of this document. Thank you.

8) How many children do you have? How old is your youngest child?

- _____

9) Does your partner have any long-term medical conditions or take any medications?

Yes / No

If yes, please explain: _____

10) Does your partner have regular monthly cycles?

Yes / No

If no, please explain: _____

11) There are two way to achieve pregnancy following vasectomy: vasectomy reversal or in vitro fertilization (IVF) with sperm retrieval. Are you and your partner considering IVF with sperm retrieval or would you like to learn more?

Yes / No

12) When performing a vasectomy reversal, we are sometimes able to retrieve sperm from the testicle that can used for IVF in the future in case the vasectomy reversal is not successful. Think of this like an 'insurance policy.' Is this something you would be interested in if you move forward with vasectomy reversal?

Yes / No

13) Besides your vasectomy, have you had any other surgeries on your genitals or in your pelvis or groin (ex. an inguinal hernia repair)?

Yes / No

If yes, please explain: _____

14) Have you ever taken testosterone, SARMs, or other anabolic steroid products?

Yes / No

If yes, please explain: _____

15) What do you do for a living?

- _____

Please complete all 4 pages of this document. Thank you.

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.