

Sexual Orientation: Heterosexual Gay Bisexual Undefined
 Marital status: Single Partnered Married Divorced Widowed
 If divorced/widowed, for how long? _____
 If in a relationship, how long have you been together? _____
 Partner's first name: _____ Partner's age: _____

If applicable, how is your relationship: _____
 If applicable, how is your sexual relationship: _____
 If applicable, does your partner contribute to your sexual problem? Yes No
 If applicable, is your partner interested in having your sexual problem treated? Yes No
 Can you go up two flights of stairs without chest pain? Yes No

Sexual History

Circle your current level of sexual interest/sexual desire/libido
 a. High b. Normal c. Low

Erectile Function

When did your sexual problem start? _____
 Was the onset sudden or gradual? Sudden Gradual
 Before the problem, how often did you have intercourse? _____
 How often do you attempt intercourse now? _____
 How often do you attempt to masturbate? _____
 Do you use any form of lubrication for masturbation? Yes No N/A
 What percent of the time are you able to penetrate? _____
 Do you often lose your erection prior to penetration? Yes No
 Do you often lose your erection during intercourse? Yes No
 Do you feel like your erect penis is shorter than it used to be? Yes No
 Do you feel like your flaccid/soft penis is shorter than it used to be? Yes No
 Has the shape of your erect penis changed? Yes No
 If yes, how long have you noticed this change? _____
 Is it still changing? Yes No How long has it been the same? _____
 What brought your attention to the change? Pain Deformity Nodule
 Is the change in shape related to any pain? Yes No
 Was there any trauma/injury to the penis? Yes No
 How much does it bother you? None Minimal Moderate Severe
 How much does it bother your partner? None Minimal Moderate Severe
 How much does it impair your life? None Minimal Moderate Severe

Please rate the level of hardness of your erections on a scale from 0 – 10, without medication,
 0 - Penis does not enlarge. **with your partner** _____/10
 1
 2
 3 - Penis is larger, but not hard.
 4
 5 - Penis is full, but not hard enough for vaginal penetration.
 6 - Penis is just hard enough for vaginal penetration, but not completely hard.
 7 - Penis is just hard enough for anal penetration, but not completely hard.
 8
 9
 10 - Penis is completely hard and fully rigid.

Using the same scale above, please rate your erections **with masturbation.** _____/10

Do you have erections in the morning? Frequently Occasional Rare None
 Using the same scale above, please rate your erections **at night / upon awakening.** _____/10

Does your ability to have an erection vary with different partners? Yes No N/A

Climax or Orgasm

Are you able to have a climax or orgasm? Yes No
If so, do you have pain with climax or orgasm? Yes No
Has there been a change in your orgasm intensity? Unchanged Reduced Increased
Does semen (fluid/cum) come out of your penis when you have orgasm? Yes No
If yes, is the amount the same as usual? Yes No
Do you usually ejaculate prior to penetration for intercourse? Yes No
About how long does intercourse last before you orgasm (climax)? _____minutes
Do you have premature ejaculation? Yes No
If yes, when did this start? _____

How well are you able to control it? Poor Fair Good
How much does it bother you? None Minimal Moderate Severe
How much does it bother your partner? None Minimal Moderate Severe

Have you noticed any change in the sensitivity of your penis? Yes No
Is intercourse ever painful for you? Yes No
If yes, where is the pain located? _____ How long does the pain last? _____
Rate the pain on a scale from 0 – 10: _____/10

Is intercourse ever painful for your partner? Yes No
Do you leak urine with sexual stimulation or arousal? Yes No Do you leak urine with a climax or orgasm? Yes No

Past Evaluation of Sexual Function

Did you ever see a doctor(s) for this problem before? Yes No
If yes, were there any diagnostic tests performed? Yes No
If yes, which ones?
1. Hormone Blood Levels Yes No
2. Penile Injection Test Yes No
3. Penile Ultrasound (Duplex) Yes No
4. Other _____

Past Treatment of Sexual Dysfunction

Were you ever treated with pills? Yes No
If yes, which ones and doses?
1. Viagra (sildenafil) 20 25 50 100 mg
Frequency _____ Rate **current** best hardness using scale on previous page ____/10
Side effects _____
2. Cialis (tadalafil) 2.5 5 10 20 mg
Frequency _____ Rate **current** best hardness using scale on previous page ____/10
Side effects _____
3. Levitra (vardenafil) 2.5 5 10 20 mg
Frequency _____ Rate **current** best hardness using scale on previous page ____/10
Side effects _____
4. Stendra (avanafil) 50 100 200 mg
Frequency _____ Rate **current** best hardness using scale on previous page ____/10
Side effects _____

Were you treated with any of the following?
1. Urethral suppositories/gels (MUSE)? Yes No
Frequency _____ Rate **current** best hardness using scale on previous page ____/10
Side effects _____
2. Penis Injections? Yes No
Medication _____ Dose _____
Frequency _____ Rate **current** best hardness using scale on previous page ____/10
Side effects _____
3. External vacuum device? Yes No
Frequency _____ Happy _____ Unhappy _____