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Note: Confidential

We would like to send a letter to update your Referring physician.

Yes No

Date: _____

Name: _____

Address: _____
_____

Age: _____ Date of Birth: _____

Referring Physician: _____

Telephone Number: _____

Primary Care Physician: _____

Telephone Number: _____

Chief Complaint:

What is the main reason for your office visit today (Please describe in detail)?

_____

_____

History of Present Sexual Function

1. Circle the current level of your interest in sexual relations.
   High About Right Less than it has been before

2. Erectile Function
   A. When did your sexual problem start? _____

   B. Was the onset sudden or gradual? _____

   C. Before the problem, how often did you have intercourse? _____

   D. How often to you attempt intercourse now? _____

   E. What percent of the time are you able to penetrate? _____

   F. When was the last time you were able to penetrate? _____

   G. Has the shape of your erect penis changed? Yes No

   H. Are you presently able to have partial erection? Yes No

   I. Do you ever lose your erection during intercourse Yes No

   J. Do you ever ejaculate with a soft penis? Yes No

K. Circle the number that best describes the quality of your erections.

1. Limp penis.
2. Full penis, no hardness, no penetration.
3. Occasional penetration, but no maintaining ability.
4. Sufficient for penetration, but no maintaining ability.
5. Able to penetrate easily and maintain to orgasm.

L. Using the same scale above, circle the number which best describes your erection with masturbation.

1 2 3 4 5 N/A

M. Do you have erections at night? _____ On awakening?_____

N. How do these erections compare with your sexually induced erections?
Same Better Worse

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

Sexual Health Inventory for Men

Patient Instructions

This questionnaire is designed to help us quantify and treat your erectile dysfunction. You will be asked to complete this questionnaire in the future to measure the success of the treatment.

Over the past six months:

1. How do you rate your confidence that you can get and keep an erection? 0 1 2 3 4 5

2. When your had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)? 0 1 2 3 4 5

3. During sexual intercourse, how often were you able to maintain your erection after you had entered your partner? 0 1 2 3 4 5

4. During sexual intercourse, rate your ability to maintain your erection to completion of intercourse. 0 1 2 3 4 5

5. When you attempted sexual intercourse, how often was it satisfactory for you? 0 1 2 3 4 5

Add the numbers corresponding to the questions 1-5.

Your score: _____

If you scored between 1-7, you may have severe erectile dysfunction.

If you scored between 8-11, you may have moderate erectile dysfunction.

If you scored between 12-16, you may have mild to moderate erectile dysfunction.

If you scored between 17-21, you may have mild erectile dysfunction.

If you scored between 22-25, you have normal erectile function.

3. Climax or Orgasm

A. Are you able to have a climax or orgasm? Yes No
B. Does semen (fluid) come out of your penis when you orgasm? Yes No
C. If yes, is the amount the same when you have/had erections? Yes No
D. Have your noticed any change in the sensitivity of your penis? Yes No

4. Sexual History

A. Sexual Orientation: Heterosexual Bisexual Homosexual
B. Are you: Married Single Widowed Divorced
C. Do you have a regular/steady partner? Yes No
D. If you are in a relationship:
1. How many years have you been together?_____
2. Describe the quality of your relationship: _____
_____
3. Describe the quality of your sexual relationship:_____
_____
4. Does your partner contribute to your sexual dysfunction? Yes No
5. Is your partner interested in having your sexual problem treated?
Yes No

5. Past Evaluation of Sexual Function

A. Did you ever see a doctor(s) for this problem before? Yes No
If yes, were there any diagnostic tests performed? Yes No
1. Hormone Blood-Level Yes No
2. Penile Injection Yes No
3.Sleep Test (Neva) Yes No
4. Penile Ultrasound (Duplex) Yes No
5. Other_____

B. Were you ever treated with pills? Yes No
If yes, which ones?
1. Viagra 25 50 100mg Yes No
Frequency_____ Result_____
2. Cialis 5 10 20mg Yes No
Frequency_____ Result_____
3. Levitra 5 10 20mg Yes No
Frequency_____ Result_____

C. Were you treated with any of the following:
1. Urethral suppositories (Muse)? Yes No
2. Penile Injections? Yes No
3. External vacuum device? Yes No

6. Any additional comments:

_____

Past Medical and Social History

1. Do you have any medical illnesses or conditions? Yes No

Circle any of the following that apply:
1. High blood pressure
2. High cholesterol levels
3. Heart disease
4. Diabetes

_____

_____

2. List all <u>serious</u> illnesses in your immediate family.

_____

_____

3. List any personal treatments and surgeries (operations) and when they occurred.

Surgery_____ Date _____

Surgery_____Date_____

Surgery_____Date_____

Radiation Therapy_____Date_____

Chemotherapy_____Date_____

4. Drug Allergies: *Yes* *No*

Please list:_____

5. Medications: *Yes* *No*

Please list all drugs, medications, eye drops, etc.

_____

_____

Do you take any medications that fall into the category of nitrates? Yes No
Do you carry nitroglycerin with you in case of emergencies? Yes No
Do you use a skin patch for the delivery of medications? Yes No