

Date: _____

ERECTILE DYSFUNCTION QUESTIONNAIRE

Please fill out the following form as honestly and completely as you can. The purpose of this information is to help assess your erectile dysfunction. Your thoroughness in its completion is essential to evaluation and treatment. All information will be held in strict confidence. Please bring this form with you on your first visit.

A. Identification:

Name: _____

Address: _____

Birthdate: _____ Birth place: _____

Age: _____

Ethnic Origin: _____

Telephone (home): _____

Telephone (work): _____

Referred by: _____

Marital Status:

single__divorced__married__separated__widowed

Partners name:_____ Her age: _____

Have you been previously treated for erectile dysfunction? _____

If yes, please date, person seen and treatment given: _____

B. Sexual History:

YES NO

1. Rate your level of sexual desire:

marked__moderate__slight__none

2. How many times each week do you have sexual intercourse? _____

3. How many times each week do you masturbate? _____

4. Do you ejaculate during sexual intercourse? _____

5. Do you ejaculate into your partners vagina? _____

6. Do you ever ejaculate prior to penetration for intercourse? _____

7. How many minutes does intercourse last before you ejaculate? _____

8. Rate your partner's level of sexual desire:

marked__moderate__slight__none

9. Does her response in any way affect your sexual performance? _____

10. How would you describe your partner's attitude towards your sexual problem:

accepting and understanding__not accepting __;

not understanding__does not care__

C. Erectile History

1. How long have you had problems with your erections? _____

2. When was the last time you had a normal erection? _____

3. Do you have firm erections now? _____

4. How would you describe the quality of your erections with intercourse:

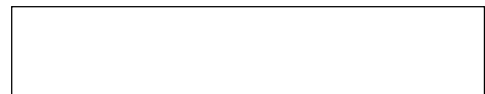
excellent__good__fair__fair__poor__none __

5. How would you describe the quality of your erections with masturbation:

excellent__good__fair__fair__poor__none __

6. Are your erections straight__or curved__?

if curved,please describe or draw a picture (include photo if possible)



	<u>YES</u>	<u>NO</u>
7. Does the duration of your erections vary at times?	_____	_____
8. Does the quality of your erections vary at times?	_____	_____
9. Do you obtain an erection easily?	_____	_____
10. Do you often have erections in the morning?	_____	_____
11. Are you aware of erections in the night?	_____	_____
12. Have you ever ejaculated through a flaccid (soft) penis?	_____	_____
13. Do you often ejaculate prior to penetration for intercourse?	_____	_____
14. Is intercourse ever painful to you?	_____	_____
15. Is intercourse painful for your partner?	_____	_____
16. Is your partners vagina so tight that you cannot penetrate?	_____	_____
17. Do you use any form of lubrication for intercourse? if so, what type _____	_____	_____

D. General Medical History:

	<u>YES</u>	<u>NO</u>	<u>AGE</u> (at diagnosis)
1. Have you ever had any of the following illnesses or conditions:			
Allergies (please list)	_____	_____	_____
Arthritis	_____	_____	_____
Bowel disorders	_____	_____	_____
Cancer	_____	_____	_____
Change in body appearance	_____	_____	_____
Change in facial appearance	_____	_____	_____
Color blindness	_____	_____	_____
Deafness	_____	_____	_____
Diabetes	_____	_____	_____
Heart problems	_____	_____	_____
Hepatitis	_____	_____	_____
Liver Disease	_____	_____	_____
Lung or breathing problems	_____	_____	_____
Thyroid disease	_____	_____	_____
Generalized viral infection	_____	_____	_____
Nervous system disease	_____	_____	_____
Sickle cell disease	_____	_____	_____
Smallpox	_____	_____	_____
Influenza	_____	_____	_____
Tuberculosis	_____	_____	_____
Ulcers	_____	_____	_____
Episodes of indigestion or abdominal pain	_____	_____	_____
Neck or back problems	_____	_____	_____
Skin diseases	_____	_____	_____
High blood pressure	_____	_____	_____

E. Urological History:

1. Have you ever had infection of the:			
prostate	_____	_____	_____
epididymis	_____	_____	_____
testicles	_____	_____	_____
2. Have you ever had: Kidney stones?	_____	_____	_____
Venereal disease (VD)?	_____	_____	_____
non-specific urethritis (NSU)?	_____	_____	_____
Gonorrhea (GC)?	_____	_____	_____

	<u>YES</u>	<u>NO</u>	<u>YEAR</u>
Syphilis	_____	_____	_____
Herpes simplex (Type I or II)	_____	_____	_____
4. Have you ever had a clear, white, yellow or green discharge from the tip of your penis?	_____	_____	_____
5. Have you ever had a urinary tract infection (UTI)?	_____	_____	_____
6. Have you had a fever in the past three months?	_____	_____	_____
7. Have you ever had blood in your semen(ejaculate)?	_____	_____	_____
8. Have you ever had pain in your scrotum or testicles?	_____	_____	_____
9. Were both of your testicles descended at birth?	_____	_____	_____
10. Have you had any injury to your testicles or penis?	_____	_____	_____
11. Have you ever had mumps?	_____	_____	_____
if yes, did it affect your testicles:	_____	_____	_____
12. Have you ever had an operation for:			
Hernia	_____	_____	_____
Varicocele (varicose veins in the scrotum)	_____	_____	_____
Hydrocele	_____	_____	_____
Undescended testis	_____	_____	_____
Any abdominal surgery	_____	_____	_____
Operation on the testis	_____	_____	_____
Vasectomy	_____	_____	_____
Circumcision or other surgery on the penis	_____	_____	_____
Other surgery (please list):	_____	_____	_____

F. Endocrine History:

	<u>YES</u>	<u>NO</u>
1. Do you have or have you ever had:		
Difficulty smelling	_____	_____
Headaches (persistent or recurrent)	_____	_____
Visual problems	_____	_____
Enlarging hands or feet	_____	_____
Problems with perspiration/sweating	_____	_____
Changing skin color	_____	_____
Frequent episodes of dizziness	_____	_____
Growth problems	_____	_____
Do you have a general sense of well being	_____	_____
Do you notice a change in your energy level	_____	_____
Do you have wide mood swings	_____	_____
2. At what age did you first:		
note armpit hair_____		
pubic hair_____		
shave_____		
3. How often do you shave:		
once a day__twice a day__once a week__twice a week or less		
4. Is there any change in the texture or quantity of body hair?_____		
5. How does your beard compare with other men in your family:		
same__sparser__heavier		

G. Occupational History:

1. What is your present occupation? _____

2. Past occupations? _____

	<u>YES</u>	<u>NO</u>
3. Is your occupation stressful?	_____	_____
4. Do you need to meet rigid deadlines or time schedules?	_____	_____
5. Do you frequently travel?	_____	_____
6. Do you fall asleep easily?	_____	_____
7. Do you wake up early?	_____	_____
8. In your work have you been exposed to any of the following:		
Prolonged heat	_____	_____
Radiation	_____	_____
Pesticides	_____	_____
Agent orange	_____	_____
Industrial solvents	_____	_____
Dyes	_____	_____
Heavy metals	_____	_____
Plastics	_____	_____

H. Medications and Drugs:

	<u>YES</u>	<u>NO</u>
1. Are you taking or have you taken any of the following medications:		
allopurinol	_____	_____
Antidepressant drugs	_____	_____
Antihistamines	_____	_____
Antihypertensive drugs	_____	_____
Antiparasite agents	_____	_____
Anti psychotic agents	_____	_____
Aspirin	_____	_____
Barbiturates	_____	_____
Chemotherapy for cancer	_____	_____
Cholestyramine	_____	_____
Clofibrate	_____	_____
Digitalis	_____	_____
Dilantin	_____	_____
Diuretics	_____	_____
Hormones (estrogen, testosterone, thyroid, cortisone)	_____	_____
Immunosuppressant drugs	_____	_____
Insulin	_____	_____
Nicotinic acid	_____	_____
Norpace	_____	_____
Penicillin	_____	_____
Streptomycin	_____	_____
Sulfa drugs	_____	_____
Tagamet (Cimetadine)	_____	_____
Tetracycline	_____	_____
Tranquilizers	_____	_____

2. Please list all medications you are currently taking (please include the dosage, frequency and length of time taking):

H. Social History:

1. Do you smoke? _____
if yes, how many cigarettes do you smoke each day? _____

2. Do you drink alcoholic beverages? _____
- If so, how often? _____
3. How many cups of coffee or caffeine-containing beverages do you drink each day? _____
4. Do you use any of the following substances:
- | | <u>YES</u> | <u>NO</u> |
|--------------|-------------------|------------------|
| Amphetamines | _____ | _____ |
| Quaaludes | _____ | _____ |
| Marijuana | _____ | _____ |
| Cocaine | _____ | _____ |
| LSD | _____ | _____ |
| Angel dust | _____ | _____ |
| Heroin | _____ | _____ |
| Methadone | _____ | _____ |
5. Do you often take long hot baths? _____

I. Family History:

1. Are any of the following diseases or conditions present in your family?
- | | | |
|-----------------------|-------|-------|
| birth defects | _____ | _____ |
| bowel disorders | _____ | _____ |
| Cancer | _____ | _____ |
| Cystic fibrosis | _____ | _____ |
| Diabetes | _____ | _____ |
| Extra fingers or toes | _____ | _____ |
| Heart disease | _____ | _____ |
| High blood pressure | _____ | _____ |
| Hormone problems | _____ | _____ |
| Kidney disease | _____ | _____ |
| Lung disease | _____ | _____ |
| Poor sense of smell | _____ | _____ |
| Tuberculosis | _____ | _____ |
| Ulcers | _____ | _____ |

PARTNER SEXUAL FUNCTION ASSESSMENT

Please fill out the following form as honestly and completely as you can. The purpose of this information is to help assess your sexual function. Your thoroughness in its completion is extremely important. All information will be held in strict confidence. Please include this page with your partners evaluation.

- 1. Rate your level of sexual desire:
marked___moderate___slight___none
- 2. How many times each week do you have sexual intercourse?
- 3. How many times each week do you masturbate?
- 4. Do you have an orgasm during sexual intercourse?
- 5. Do you have adequate lubrication of your vagina?
- 6. Do you ever have an orgasm prior to penetration for intercourse?
- 7. How many minutes does intercourse last before you ejaculate?
- 8. Rate your partner's level of sexual desire:
marked___moderate___slight___none
- 9. Does her response in any way affect your sexual performance?
- 10. How would you describe your partner's attitude towards your sexual problem:
accepting and understanding___not accepting ___; not understanding___does not care___
- 11. What type of contraceptive do you use?
- 11. How long have you had problems with your sexual function?
- 12. When was the last time you had normal sexual function?

- | | YES | NO |
|---|------------|-----------|
| 13. Does your sexual function vary at times? | ___ | ___ |
| 14. Does the quality of your sexual function vary at times? | ___ | ___ |
| 15. Do you often have an orgasm prior to penetration for intercourse? | ___ | ___ |
| 16. Is intercourse ever painful to you? | ___ | ___ |
| 17. Is intercourse painful for your partner? | ___ | ___ |
| 18. Is your vagina so tight that it is difficult for your partner to penetrate? | ___ | ___ |
| 19. Do you use any form of lubrication for intercourse?
if so, what type | ___ | ___ |

International Index of Erectile Function Questionnaire and Response Options
(MALE US Version)

Questions (over the past 4 weeks)

Response Options

- 0= No sexual activity
- 1= Almost never/never
- 2= A few times (much less than half the time)
- 3= Sometimes (about half the time)
- 4= Most times (much more than half the time)
- 5= Almost always/always

____ Q1: How often were you able to get an erection during sexual activity?

____ Q2: When you had erections with sexual stimulation, how often were your erections hard enough for penetration?

- 0= Did not attempt intercourse
- 1= Almost never/never
- 2= A few times (much less than half the time)
- 3= Sometimes (about half the time)
- 4= Most times (much more than half the time)
- 5= Almost always/always

____ Q3: When you attempted sexual intercourse, how often were you able to penetrate (enter) your partner?

____ Q4: During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

- 0= Did not attempt intercourse
- 1= Extremely difficult
- 2= Very difficult
- 3= Difficult
- 4= Slightly difficult
- 5= Not difficult

____ Q5: During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

- 0= No attempts
- 1= One to two attempts
- 2= Three to four attempts
- 3= Five to six attempts
- 4= Seven to ten attempts
- 5= Eleven + attempts

____ Q6: How many times have you attempted sexual intercourse?

- 0= Did not attempt intercourse
- 1= Almost never/never
- 2= A few times (much less than half the time)
- 3= Sometimes (about half the time)
- 4= Most times (much more than half the time)
- 5= Almost always/always

____ Q7: When you attempted sexual intercourse, how often was it satisfactory for you?

- 0= No intercourse
- 1= No enjoyment
- 2= Not very enjoyable
- 3= Fairly enjoyable
- 4= Highly enjoyable
- 5= Very highly enjoyable

_____ Q8: How much have you enjoyed sexual intercourse?

- 0= No sexual stimulation /intercourse
- 1= Almost never/never
- 2= A few times (much less than half the time)
- 3= Sometimes (about half the time)
- 4= Most times (much more than half the time)
- 5= Almost always/always

_____ Q9: When you had sexual stimulation or intercourse, how often did you ejaculate?

_____ Q10: When you had sexual stimulation or intercourse, how often did you have the feeling of orgasm or climax?

- 1= Almost never/never
- 2= A few times (much less than half the time)
- 3= Sometimes (about half the time)
- 4= Most times (much more than half the time)
- 5= Almost always/always

_____ Q11: How often have you felt sexual desire?

- 1= Very low/none at all
- 2= Low
- 3= Moderate
- 4= High
- 5= Very high

_____ Q12: How would you rate your level of sexual desire?

- 1= Very Dissatisfied
- 2= Moderately dissatisfied
- 3= About equally satisfied and dissatisfied
- 4= Moderately satisfied
- 5= Very satisfied

_____ Q13: How satisfied have you been with your overall sex life?

_____ Q14: How satisfied have you been with your sexual relationship with your partner?

- 1= Very low
- 2= Low
- 3= Moderate
- 4= High
- 5= Very high

_____ Q15: How do you rate your confidence that you could get an erection?

_____ TOTAL