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## Evaluation Questionnaire For Impotence or Sexual Dysfunction

Your response to the items on this Questionnaire will allow us to make a preliminary decision about the proper diagnosis and treatment programs. Please use back of paper for more description of each item if needed.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please describe in your own words your past sexual history. Include in this description your current problem and how it affects your life. (If more space is needed, please use the back of page.)

### **Characteristics of erection.**

Do you have erections at all?

Yes \_\_\_\_\_ No \_\_\_\_\_

Are you able to get sufficient erections to make

Vaginal intercourse?

Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_ Never

\_\_\_\_\_ Rarely

\_\_\_\_\_ Almost half the time

\_\_\_\_\_ Most of the time

\_\_\_\_\_ Always

Do you ever awaken in the morning with an erection?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, is it:

\_\_\_\_\_ Full

\_\_\_\_\_ Partial

\_\_\_\_\_ Poor

If you have an erection, do you lose the erection before or after vaginal penetration?

\_\_\_\_\_ Before  
\_\_\_\_\_ After

Do the quality of erections improve occasionally?  
If yes, under what circumstances? Describe:

Yes \_\_\_\_\_ No \_\_\_\_\_

**Characteristics of sexual desire**

How strong is your desire for sexual intercourse?

Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_ Poor  
\_\_\_\_\_ Fair  
\_\_\_\_\_ Strong  
\_\_\_\_\_ Very Strong

How strong is the desire of your wife or sexual partner?

Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_ Poor  
\_\_\_\_\_ Fair  
\_\_\_\_\_ Strong  
\_\_\_\_\_ Very Strong

How long have you been with your current sexual partner? \_\_\_\_\_

What is your wife/sexual partner's attitude about sex? Describe:

Does your wife/sexual partner have problems with getting an orgasm or climax?

Yes \_\_\_\_\_ No \_\_\_\_\_

Does your wife/sexual partner have any sexual dysfunction?

Yes \_\_\_\_\_ No \_\_\_\_\_

Are you or your wife/sexual partner overweight?

Yes \_\_\_\_\_ No \_\_\_\_\_

How long has it been since you have had sexual intercourse? \_\_\_\_\_

How long has it been since your last orgasm? \_\_\_\_\_

**Treatment History:** (For any questions that you answer "YES", please describe or give details on the bottom section on page 3)

Have you had a complete physical exam lately? Yes \_\_\_\_\_ No \_\_\_\_\_

When: \_\_\_\_\_

Doctor: \_\_\_\_\_

Have you seen your doctor for treatment of this problem? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when: \_\_\_\_\_

Who was the treating doctor: \_\_\_\_\_

What was the treatment? \_\_\_\_\_

Have you had a hormonal evaluation? (blood tests) Yes \_\_\_\_\_ No \_\_\_\_\_

Have you consulted with any mental health counselor? (specialist, psychiatrist, psychologist or social worker) Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had a vascular (Blood flow) evaluation? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had nocturnal tumescence testing? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had a heart attack or heart problem? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had major surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list:

Are you diabetic (sugar)? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your penis curve in any direction when erect? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, for how long? \_\_\_\_\_

Does your penis curve in this or another direction when not erect? \_\_\_\_\_

Have you had any serious injuries or accidents? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you now or have you ever had problems with your prostate? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had sexually transmitted diseases? (venereal diseases) Yes \_\_\_\_\_ No \_\_\_\_\_

Do you suffer from cold fingers and toes? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, how many packs per day? \_\_\_\_\_  
If yes, for how many years? \_\_\_\_\_

Urinary frequency: Times per day \_\_\_\_\_ Times per night \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had back problems? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have pre-mature ejaculation? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you take any daily or weekly medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list all your current medical problems and what medications that you take for these problems: