John J. Bauer, M.D., F.A.C.S.
www.flinturology.com
Urology Services, Inc.
G-1121 West Hill Rd.
Flint, Michigan 48507
Tel: 810.232.8888
Fax: 810.232.9190
Email: jbauer@flinturology.com

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? Yes_____ No_____
If yes, under what circumstances? Describe:

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? Yes_____ No_____
(blood tests)

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: