PEYRONIE'S DISEASE QUESTIONNAIRE

NAME: _____
Last First Middle

BIRTHDATE: _____ OCCUPATION: _____

REFERRING PHYSICIAN NAME: _____

REFERRING PHYSICIAN SPECIALTY (Urologist, Internist, etc.): _____

PRIMARY CARE PHYSICIAN NAME: _____

PATIENT HISTORY

AGE (YEARS): _____

APPROXIMATE DURATION OF PROBLEM IN YEARS: _____

ONSET OF THE PROBLEM WAS: Gradual Sudden (Circle One)

If sudden, was it related in onset to: (Circle One)

Surgery New medication Life event Penile injury

ARE YOUR ERECTIONS BENT (Y,N): _____

WHAT IS THE DIRECTION OF THE BEND (UP, DOWN, LEFT, RIGHT): _____

HOW MUCH IS THE PENIS BENT WITH AN ERECTION (DEGREES): _____

HAS THE CURVATURE CHANGED DURING THE PAST 6 MONTHS (Y,N): _____

DO YOU EXPERIENCE PAIN IN THE PENIS WITH ERECTIONS (Y,N): _____

HAVE YOU NOTED A LUMP INSIDE YOUR PENIS (Y,N): _____

HAS YOUR PENIS GOTTEN SHORTER SINCE THIS PROBLEM STARTED (Y,N): _____

DO YOU CURRENTLY HAVE AN ACTIVE SEXUAL PARTNER (WIFE, GIRLFRIEND, OTHER, NONE): ___

DOES THE PENILE CURVATURE PREVENT SEXUAL INTERCOURSE (Y,N): _____

DOES THE BEND CAUSE PAIN TO YOUR PARTNER (Y,N): _____

DO YOU HAVE A FAMILY HISTORY OF PEYRONIE'S DISEASE (Y,N): _____

DOES ANYONE IN YOUR FAMILY HAVE SCAR TISSUE IN THEIR HANDS (Y,N): _____

DO YOU RECALL INJURING YOUR PENIS (Y,N): _____

HAS YOUR PENIS EVER BEEN FORCIBLY BENT WHILE ERECT (Y,N): _____

IS THE RIGIDITY OF YOUR ERECTIONS SATISFACTORY FOR SEXUAL INTERCOURSE (Y,N): _____

PRESENT SEXUAL FUNCTION:

Over the past 30 days, how often have you had partial or full erections when you were sexually stimulated in any way? (circle one)

0-did not engage in any sexual activity
1-almost 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

Over the past 30 days, when you had erections, how often were the erections firm enough to have sexual relations? (circle one)

0-did not engage in any sexual activity
1-almost 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

When you attempted sexual intercourse, how often were you able to penetrate (enter) your partner? (circle one)

0-did not attempt intercourse
1-almost never
2-a few times (much less than half)
3-sometimes (about half the time)
4-most times (much more than half the time)
5-almost always/always

During sexual intercourse, <u>how difficult</u> was it to maintain your erection to completion of intercourse? (circle one)

0-unable to attempt intercourse
1-extremely difficult
2-very difficult
3-difficult
4-slightly difficult
5-not difficult

When you attempted sexual intercourse, how often was your erection satisfactory in your opinion? (circle one)

0-did not attempt intercourse
1-almost never/never
2-a few times (much less than half)
3-sometimes (about half the time)
4-most times (much more than half the time)
5-almost always/always

How would you rate your level of sexual desire? (circle one)

1-very low/none at all 2-low 3-moderate 4-high 5-very high

What is the quality of the best erection you have experienced during the night or upon awakening in the morning during the past month?

1-none at all 2-partial (less than half) 3-partial (better than half) 4-full erection

What is the rigidity of your penis upon achieving orgasm? (circle one)

1-unable to achieve orgasm

2-no erection at all

3-partial (equal to or less than half erect)

4-partial (better than half erect)

5-full erection

Can you achieve an orgasm?	YES	NO	(Circle One)
Can you ejaculate normally?	YES	NO	(Circle One)
Do you have premature ejaculation?	YES	NO	(Circle One)

PREVIOUS EVALUATION AND TREATMENT:

Have you undergone evaluation for this problem?	YES	NO	(Circle One)

Comment: _____

Have you tried Vitamin E?	YES	NO	(Circle One)
Did Vitamin E work to your satisfaction?		YES	NO (Circle One)
Have you tried POTABA?	YES	NO	(Circle One)
Did POTABA work to your satisfaction?		YES	NO (Circle One)
Have you received any verapamil penile injections?	YES	NO	(Circle One)
Did the injections help?		YES	NO (Circle One)
Have you undergone penile straightening?	YES	NO	(Circle One)
Did it work initially?		YES	NO (Circle One)
Have you tried Viagra, Cialis or Levitra?	YES	NO	(Circle One)
Did it work to your satisfaction?	YES	NO	(Circle One)
Have you tried any other treatments?	YES	NO	(Circle One)

What was this treatment? _____

RISK FACTORS FOR ERECTILE DYSFUNCTION:

Do you ride a bicycle regularly?	YES	NO	(Circle One)
Have you ever smoked cigarettes regularly?	YES	NO	(Circle One)
If so, do you currently smoke?	YES	NO	(Circle One)
Have you ever had problems with excessive alcohol drinking?	YES	NO	(Circle One)
Have you injured your spinal cord?	YES	NO	(Circle One)
Have you had your prostate removed for cancer?	YES	NO	(Circle One)
Have you undergone radiation therapy for prostate cancer?	YES	NO	(Circle One)
Have you had prostate surgery (TURP) for benign prostatic growth?	YES	NO	(Circle One)

How many children do you have? (Number) _____

PAST MEDICAL HISTORY:

Are you being treated for diabetes mellitus?	YES	NO	(Circle One)

If so, which treatment method are you using to control your sugar? (Circle one)

Diet Pills Insulin

Are you being treated for high blood pressure?	YES	NO	(Circle One)
Are you being treated for elevated blood cholesterol level?	YES	NO	(Circle One)
Do you have heart disease?	YES	NO	(Circle One)
Have you ever had a stroke?	YES	NO	(Circle One)
Have you been told that you have hardening of the arteries?	YES	NO	(Circle One)
Are you or have you been treated for depression?	YES	NO	(Circle One)

Other medical illnesses: _____

Past Surgery: _____

List your medications: _____

Do you take aspirin regularly? YES NO (Circle One)

List any medications that you are allergic to:: _____

PHYSICAL EXAMINATION

(To be filled out by Physician)

WEIGHT (LBS): _____ HEIGHT (Inches): _____ RACE: _____

TEMP.: _____ PULSE: _____ RESP.: _____

Phallus (N/A): _____ Meatus (N/A): _____

Circumcised (Y/N): _____ Plaque (Y/N): _____

Secondary Sex Characteristics (Normal, Abnormal): _____

Dupuytren's Contractures (Y/N): _____

TESTES EXAM:

RIGHT	LEFT
LOCATION (S,I,A,O): _____	LOCATION (S,I,A,O): _____
SIZE: _____	SIZE: _____
HYDROCELE (Y/N): _____	HYDROCELE (Y/N): _____
VARICOCELE (N,L,M,S): _____	VARICOCELE (N,L,M,S): _____
HERNIA (Y/N): _____	HERNIA (Y/N): _____

PROSTATE (N/A): _____

PULSES (I/D): _____ CAROTID BRUIT (Y/N): _____

Diagnosis #1: _____ Diagnosis #2: _____