

DATE \_\_\_\_\_

JHH# \_\_\_\_\_

## ERECTILE DYSFUNCTION QUESTIONNAIRE

NAME: \_\_\_\_\_  
Last First Middle

BIRTHDATE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

REFERRING PHYSICIAN NAME: \_\_\_\_\_

REFERRING PHYSICIAN SPECIALTY (Urologist, Internist, etc.): \_\_\_\_\_

PRIMARY CARE PHYSICIAN NAME: \_\_\_\_\_

### **PATIENT HISTORY**

AGE: \_\_\_\_\_

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

### **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, how difficult 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

Do you have an active sexual partner at this time? (Wife, Girlfriend, Other, None): \_\_\_\_\_

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)
Do you think there is an emotional cause?	YES	NO	(Circle One)

Do you experience any pain with erections?	YES	NO	(Circle One)
Are or were your erections abnormally bent?	YES	NO	(Circle One)
If so, Which direction is it bent? (Up, Down, Left, Right): _____			
How many degrees is the bend? _____			
Have you noted any change in the bend during the past six months?	YES	NO	(Circle One)

**PREVIOUS EVALUATION:**

<b>Have you had your testosterone level measured?</b>	<b>YES</b>	<b>NO</b>	<b>(Circle One)</b>
If so, what were the results? (Normal, Abnormal, Don't know): _____			
<b>Have you ever received a penile injection?</b>	<b>YES</b>	<b>NO</b>	<b>(Circle One)</b>
If so, did it produce a full erection?	YES	NO	(Circle One)
<b>Have you undergone a penile blood flow study?</b>	<b>YES</b>	<b>NO</b>	<b>(Circle One)</b>
If so, What was the result? (Normal, Abnormal, Do not know): _____			
<b>Have you undergone testing of erections during sleep?</b>	<b>YES</b>	<b>NO</b>	<b>(Circle One)</b>
If so, What was the result? (Normal, Abnormal, Do not know) _____			

**PREVIOUS TREATMENT:**

<b>Have you tried Viagra, Levitra or Cialis?</b>	<b>YES</b>	<b>NO</b>	<b>(Circle One)</b>
Did Viagra work to your satisfaction?		YES	NO (Circle One)
<b>Have you tried MUSE?</b>	<b>YES</b>	<b>NO</b>	<b>(Circle One)</b>
Did MUSE produce a satisfactory erection?		YES	NO (Circle One)
Do you like using MUSE?		YES	NO (Circle One)
<b>Have you tried injection therapy?</b>	<b>YES</b>	<b>NO</b>	<b>(Circle One)</b>
Did the injections produce a satisfactory erection?		YES	NO (Circle One)
Do you like doing injections?		YES	NO (Circle One)
<b>Have you tried the vacuum device?</b>	<b>YES</b>	<b>NO</b>	<b>(Circle One)</b>
Did it work?		YES	NO (Circle One)
Do you like the vacuum device?		YES	NO (Circle One)
<b>Have you tried any other treatments?</b>	<b>YES</b>	<b>NO</b>	<b>(Circle One)</b>
What was this treatment? _____			

**RISK FACTORS FOR ERECTILE DYSFUNCTION:**

Have you ever injured your penis?	YES	NO	(Circle One)
Has your penis ever been forcibly bent while erect?	YES	NO	(Circle One)
Have you had a straddle injury?	YES	NO	(Circle One)
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 medications: \_\_\_\_\_

Do you take aspirin regularly?	YES	NO	(Circle One)
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**List any medications that you are allergic to:** \_\_\_\_\_

**FAMILY HISTORY:**

Do you have a family history of:

High blood pressure (Y/N): _____	Diabetes (Y/N): _____
Heart disease (Y/N): _____	Prostate cancer (Y/N): _____
Peyronie's disease (Y/N): _____	Cancer (Y/N): _____

# PHYSICAL EXAMINATION

(To be filled out by Physician)

WEIGHT (LBS): \_\_\_\_\_ HEIGHT (In): \_\_\_\_\_ 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

LOCATION (S,I,A,O): \_\_\_\_\_

SIZE: \_\_\_\_\_

HYDROCELE (Y/N): \_\_\_\_\_

VARICOCELE (N,L,M,S): \_\_\_\_\_

HERNIA (Y/N): \_\_\_\_\_

### LEFT

LOCATION (S,I,A,O): \_\_\_\_\_

SIZE: \_\_\_\_\_

HYDROCELE (Y/N): \_\_\_\_\_

VARICOCELE (N,L,M,S): \_\_\_\_\_

HERNIA (Y/N): \_\_\_\_\_

PROSTATE (N/A): \_\_\_\_\_

PULSES (I/D): \_\_\_\_\_ CAROTID BRUIT (Y/N): \_\_\_\_\_

LABORATORY TESTS:

FREE TESTOSTERONE: \_\_\_\_\_

PROLACTIN: \_\_\_\_\_

LH: \_\_\_\_\_

SMAC: \_\_\_\_\_

CRANIAL MRI: \_\_\_\_\_

DUPLEX ULTRASOUND: \_\_\_\_\_

NPT: \_\_\_\_\_

PER: \_\_\_\_\_

PET: \_\_\_\_\_

DICC: \_\_\_\_\_

TREATMENTS:

VIAGRA: \_\_\_\_\_

PEP: \_\_\_\_\_

VED: \_\_\_\_\_

MUSE: \_\_\_\_\_

IMPLANT: \_\_\_\_\_

COUNSELING: \_\_\_\_\_

Diagnosis #1: \_\_\_\_\_

Diagnosis #2: \_\_\_\_\_