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:

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

PREVIOUS TREATMENT:

Have you tried Viagra, Levitra or Cialis?  YES  NO  (Circle One)
   Did Viagra work to your satisfaction?  YES  NO  (Circle One)
Have you tried MUSE?  YES  NO  (Circle One)
   Did MUSE produce a satisfactory erection?  YES  NO  (Circle One)
   Do you like using MUSE?  YES  NO  (Circle One)
Have you tried injection therapy?  YES  NO  (Circle One)
   Did the injections produce a satisfactory erection?  YES  NO  (Circle One)
   Do you like doing injections?  YES  NO  (Circle One)
Have you tried the vacuum device?  YES  NO  (Circle One)
   Did it work?  YES  NO  (Circle One)
   Do you like the vacuum device?  YES  NO  (Circle One)
Have you tried any other treatments?  YES  NO  (Circle One)
   What was this treatment? ___________________________
RISK FACTORS FOR ERECTILE DYSFUNCTION:

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>(Circle One)</th>
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</thead>
<tbody>
<tr>
<td>Have you ever injured your penis?</td>
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<td>Has your penis ever been forcibly bent while erect?</td>
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<td>Have you had a straddle injury?</td>
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<td>Do you ride a bicycle regularly?</td>
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<td>Have you ever smoked cigarettes regularly?</td>
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<td>If so, do you currently smoke?</td>
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<td>Have you ever had problems with excessive alcohol drinking?</td>
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<td>Have you injured your spinal cord?</td>
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<td>Have you had your prostate removed for cancer?</td>
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<td>Have you undergone radiation therapy for prostate cancer?</td>
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<td>Have you had prostate surgery (TURP) for benign prostatic growth?</td>
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<td>How many children do you have?</td>
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PAST MEDICAL HISTORY:

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>(Circle One)</th>
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<tbody>
<tr>
<td>Are you being treated for diabetes mellitus?</td>
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<td>If so, which treatment method are you using to control your sugar? (Circle one)</td>
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<tr>
<td>Diet</td>
<td>Pills</td>
<td>Insulin</td>
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<tr>
<td>Are you being treated for high blood pressure?</td>
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<tr>
<td>Are you being treated for elevated blood cholesterol level?</td>
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<td>Do you have heart disease?</td>
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<td>Have you ever had a stroke?</td>
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<td>Have you been told that you have hardening of the arteries?</td>
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<td>Are you or have you been treated for depression?</td>
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<td>Other medical illnesses:</td>
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<td>Past Surgery:</td>
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<td>List medications:</td>
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<td>Do you take aspirin regularly?</td>
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<td>List any medications that you are allergic to:</td>
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<td>FAMILY HISTORY:</td>
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<tr>
<td>Do you have a family history of:</td>
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<tr>
<td>High blood pressure (Y/N):</td>
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<td>Heart disease (Y/N):</td>
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<td>Peyronie’s disease (Y/N):</td>
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<td>Diabetes (Y/N):</td>
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<td>Prostate cancer (Y/N):</td>
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<td>Cancer (Y/N):</td>
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Version: 10/02/07
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:

<table>
<thead>
<tr>
<th>RIGHT</th>
<th>LEFT</th>
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<tbody>
<tr>
<td>LOCATION (S,I,A,O): ____________</td>
<td>LOCATION (S,I,A,O): ____________</td>
</tr>
<tr>
<td>SIZE: _________________________</td>
<td>SIZE: _________________________</td>
</tr>
<tr>
<td>HYDROCELE (Y/N): ______________</td>
<td>HYDROCELE (Y/N): ______________</td>
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<tr>
<td>VARICOCELE (N,L,M,S): __________</td>
<td>VARICOCELE (N,L,M,S): __________</td>
</tr>
<tr>
<td>HERNIA (Y/N): _________________</td>
<td>HERNIA (Y/N): _________________</td>
</tr>
</tbody>
</table>

PROSTATE (N/A):________________________________________

PULSES (I/D): ____________  CAROTID BRUIT (Y/N): __________
LABORATORY TESTS:

FREE TESTOSTERONE: _______  DUPLEX ULTRASOUND: ____________
PROLACTIN: _____________  NPT: _______________
LH: _________________  PER: ______________
SMAC: _______________  PET: ______________
CRANIAL MRI: ____________  DICC: ____________

TREATMENTS:

VIAGRA: ____________  MUSE: ___________
PEP: _______________  IMPLANT: __________
VED: ________________  COUNSELING: _______

Diagnosis #1: ____________________  Diagnosis #2: ____________________