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, 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

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: _________________________________________________________________

<table>
<thead>
<tr>
<th>Have you tried Vitamin E?</th>
<th>YES</th>
<th>NO</th>
<th>(Circle One)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did Vitamin E work to your satisfaction?</td>
<td>YES</td>
<td>NO</td>
<td>(Circle One)</td>
</tr>
<tr>
<td>Have you tried POTABA?</td>
<td>YES</td>
<td>NO</td>
<td>(Circle One)</td>
</tr>
<tr>
<td>Did POTABA work to your satisfaction?</td>
<td>YES</td>
<td>NO</td>
<td>(Circle One)</td>
</tr>
<tr>
<td>Have you received any verapamil penile injections?</td>
<td>YES</td>
<td>NO</td>
<td>(Circle One)</td>
</tr>
<tr>
<td>Did the injections help?</td>
<td>YES</td>
<td>NO</td>
<td>(Circle One)</td>
</tr>
<tr>
<td>Have you undergone penile straightening?</td>
<td>YES</td>
<td>NO</td>
<td>(Circle One)</td>
</tr>
<tr>
<td>Did it work initially?</td>
<td>YES</td>
<td>NO</td>
<td>(Circle One)</td>
</tr>
<tr>
<td>Have you tried Viagra, Cialis or Levitra?</td>
<td>YES</td>
<td>NO</td>
<td>(Circle One)</td>
</tr>
<tr>
<td>Did it work to your satisfaction?</td>
<td>YES</td>
<td>NO</td>
<td>(Circle One)</td>
</tr>
<tr>
<td>Have you tried any other treatments?</td>
<td>YES</td>
<td>NO</td>
<td>(Circle One)</td>
</tr>
<tr>
<td>What was this treatment?</td>
<td>__________________________</td>
<td></td>
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</tbody>
</table>
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: ______________

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