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:

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:

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)

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	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): _____

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: _____