CHOICES IN HEALTH

Where leading-edge medicine meets innovative care

SPECIAL SEXUAL FUNCTION

Date: _____

Your responses to the items on this questionnaire will allow us to make a preliminary decision about arrangements necessary for the proper diagnostic and treatment program.

1. IDENTIFICATION INFORMATION

Name _____

Address _____

Street City State Zip

Occupation _____

Birth Date _____

Present Marital Status S M W D

No. Previous Marriages _____

Your Doctor's Name _____

Your Doctor's Address _____

Your Doctor's Phone Number _____ Area Code _____

Your Doctor's Specialty _____ General Practice _____

Urology _____ Other (Specify) _____

Would you like us to send copies of our findings to your physician? _____ Yes _____ No

2. Please describe in your own words your past sexual history; include in this description your current problem and how this problem affects your life. (If more space is needed, use back of page.)

_____

_____

_____

3. Please give a brief description of your social-educational background (parent, marital status, children, social environment, etc.); include the items that you feel may be important to us in assessing the potential value of this treatment or in selecting the best treatment to suit your case.

_____

_____

_____

4. CHARACTERISTICS OF ERECTION

a) Do you have erections at all? _____ Yes _____ No

b) Are you able to get sufficient erection to make vaginal penetration? _____ Never _____ Rarely _____Half the time _____ Most of the time _____Always

c) Do you ever awaken in the morning with an erection? _____ Yes _____ No
If so, is it _____ full, _____ partial, or _____ poor?

d) Have you noticed a change in the firmness of these early morning erections? _____ Yes _____ No

e) Does the quality of your erections improve occasionally? _____ Yes _____ No

f) Do you notice any curvature of the penis during erection? _____ Yes _____ No

g) Did the start of your current erection problem happen _____ suddenly _____ slowly _____ currently happening intermittently

h) Did you experience an extremely stressful event around the time your erection problem began?____ Yes ____ No

i) Do you find it easier to obtain an erection while on vacation? _____ Yes _____ No

5. CHARACTERISTICS OF PENIS

Are you concerned about the size of your penis? _____ Yes _____ No

If so, what is the problem? _____

6. CHARACTERISTICS OF ORGASM OR CLIMAX

a) Do you now have orgasms or climaxes? _____ Yes _____ No

If so, how often? _____

If not, how often before your problem developed? _____

If so, how is orgasm achieved? _____

vaginal penetration _____
by hand _____
orally _____
conventional method with partner but without penetration _____
other (describe) _____

If so, does semen (sperm) or liquid come out? _____ Yes _____ No

b) Can you masturbate to climax? _____ Yes _____ No
If so, does the penis get hard then? _____ Yes _____ No

c) Do you experience "premature" ejaculation? _____ Yes _____ No

d) Do you experience pain with ejaculation or climax? _____ Yes _____ No

7. CHARACTERISTICS OF SEXUAL DESIRE

a) How strong is your desire for sexual intercourse? _____ Poor _____ Fair _____ Strong _____ Very Strong

b) How strong is the desire of your wife or sexual partner? _____ Poor _____ Fair _____ Strong _____ Very Strong

c) How long with current sexual partner? _____

d) What is your partner's attitude about your having an operation to treat impotence? _____

8. PAST MEDICAL HISTORY

a) Have you seen a doctor for treatment of your problem? _____ Yes _____ No
If so, please describe the treatment and results: _____

b) Have you consulted any kind of mental health counselor (specialist, psychiatrist, psychologist, or social worker) about your problem? _____ Yes _____ No
If so, describe when and the results (include name and address) _____

c) Do you take any daily or weekly medications? _____ Yes _____ No
If so, list them and indicate purpose: Drug: _____ Dosage: _____ Purpose: _____

d) How often do you drink alcoholic beverages?
1. Never
2. Once or twice a year
3. Once or twice a month
4. Every weekend
5. Several times a week
6. Every day

e) How much do you drink?
1. don't drink
2. 1 drink
3. 2-3 drinks
4. 4-7 drinks
5. 8 or more drinks
6. until "high" or drunk

f) What is your usual drink? _____

g) Do you use any "street drugs"? _____ Yes _____ No
If so, please name _____

h) Do you use tobacco products? _____ Yes _____ No
If so, how much? _____

i) Have you had surgery in the past? _____ Yes _____ No
If so, please list: Surgery _____ Date _____

j) Have you had any serious accidents? _____ Yes _____ No

k) Do you have any history of the following:
Heart disease _____
High blood pressure _____
High cholesterol _____
Pain in legs, thigh or hips with walking or exercising _____
Numbness in your penis or legs _____
Diabetes _____
Headaches _____
Prostatitis or urinary tract infections _____
Thyroid disorders _____
Difficulty sleeping _____
Appetite change _____
Change in bowel habits _____
Difficulty with urination _____

9. Is there any further information you feel is important to your problem? _____

_____