

Central Maryland Urology Associates, PA
Urology Patient Sexual Dysfunction Questionnaire

Name: _____ Date: _____ Age: _____

Referring Physician: _____

The following information is CONFIDENTIAL. *Information contained here will not be released to anyone without your authorization to do so.*

CHIEF COMPLAINT: SEXUAL DYSFUNCTION

Describe your current sexual problems. If your problem is with erections, do you have more trouble getting an erection, maintaining an erection, or both?

Do you have a steady sexual partner? Yes No Other (explain)

When did your current sexual problems begin? _____

Was the onset sudden or gradual? Sudden Gradual Other (explain)

Why do you think you are having sexual problems?

Psychological? _____

Physical? _____

When was the last time you had successful intercourse? _____

Are (or were) your erections straight or curved? _____

Are (or were) your erections painful? Yes No Other (explain)

How does your sexual partner view your problem? _____

Do you talk about it? Yes No

Are there problems developing due to the sexual problem? Yes No

What treatment plans have you heard about? (Please circle)

 Psychological counseling

 Penile implants

 Hormone injections

 Vacuum pumps

 Urethral suppositories

 Yohimbine

How old were you when you became sexually active with partners? _____

Have you ever been sexually abused? Yes No

Add any information that you believe to be helpful. _____

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Circle the following with Yes, No or N/A (not applicable).

Do you get firm erections under any of the following conditions:

- | | | | |
|---|-----|----|----------------|
| ➤ Early morning/awakening from sleep | Yes | No | N/A |
| ➤ With the need to urinate | Yes | No | N/A |
| ➤ Manual stimulation – self | Yes | No | N/A |
| ➤ Manual stimulation – partner | Yes | No | N/A |
| ➤ Oral stimulation | Yes | No | N/A |
| ➤ Anal sex | Yes | No | N/A |
| ➤ Female partner other than spouse | Yes | No | N/A |
| ➤ Male partner | Yes | No | N/A |
| ➤ Erotic clothing on self or partner | Yes | No | N/A |
| ➤ Vacation times | Yes | No | N/A |
| ➤ Unusual places other than bedroom | Yes | No | N/A |
| ➤ Erotic books, magazines, videos | Yes | No | N/A |
| ➤ Are erections ever sufficient for vaginal intercourse? | | | |
| | Yes | No | N/A |
| ➤ Do you lose erections with intercourse? | Yes | No | N/A |
| ➤ Do you lose erections before ejaculation? | | | |
| | Yes | No | N/A |
| ➤ Are you still able to have an orgasm? | Yes | No | N/A |
| ➤ Does semen come out of your penis normally? | | | |
| | Yes | No | N/A |
| ➤ How would you describe your sex drive or libido on a scale from 1-10? | | | |
| 1 2 3 4 5 6 7 8 9 10 | | | |
| lowest desire | | | highest desire |

Do you have any significant medical problems? Please list. _____

List all of the surgeries you have ever had: _____

Are you allergic to any medications? _____

List the NAMES (and DOSE if known) of the medications you take daily, including aspirin.

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SOCIAL HISTORY:

Are you: Single Married Widowed Separated Other

Do you have a living will? _____

What is your occupation? _____

Do you smoke cigarettes? Yes No How much? How often?

Do you drink alcohol? Yes No How much? How often?

Caffeine use? Yes No How much? How often?

FAMILY HISTORY:

Have you or any member of your family had cancer or any other disease of the kidney, bladder, prostate or testicles?

Father Mother Brother Sister Children Self

Physician Use only:

# Answer	Level of Service
0	1 or 2
1-2	3
3	4 or 5

