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SEXUAL QUESTIONAIRE

NAME: _____ **DATE:** _____

Please answer the following questions as best as you can. If you need more room to write, continue on the back. If you don't understand a term or it is not clear, ask.

MARITAL STATUS: _____

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? (Y) (N) (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? _____

Describe your sex life before your current problem. _____

_____

_____

Describe any treatment you have had for this problem and include names and addresses of the persons who have treated you. _____

_____

_____

Circle the following:

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, magazine, videos	Yes	No	N/A

Are erections ever sufficient for vaginal intercourse?	Yes	No
Do you lose erections during intercourse?	Yes	No
Do you lose erections before ejaculation?	Yes	No
Are you still able to have an orgasm (ejaculate)?	Yes	No
Does semen come out of your penis normally?	Yes	No

How would you rate your sex drive or libido or desire on a scale from 1 – 10?
1 is the lowest and 10 is highest _____

Do you have any of the following conditions:

Diabetes	Yes	No
Hypertension (high blood pressure)	Yes	No
Nervous condition	Yes	No
Thyroid problems	Yes	No
Cancer	Yes	No
Chronic pain	Yes	No
Back problems	Yes	No
Poor circulation	Yes	No
Difficulty urinating	Yes	No
Constipation	Yes	No
Leg or calf pain while walking	Yes	No

Have you ever had any surgeries on your:

Back	**Yes**	**No**
Rectum	**Yes**	**No**
Blood vessels	**Yes**	**No**
Colon	**Yes**	**No**
Prostate	**Yes**	**No**

Have you ever seen a psychotherapist about this or any other problems? Yes No
If yes, please explain situation on back of this page.

How much alcohol do you consume? (Include types, amounts and frequency)_____
For how many years? _____

How many packs of cigarettes do you smoke in an average day? _____
How long have you smoked? _____
If you stopped, how long have you been a non-smoker? _____

How does your sexual partner view your problem? _____
Do you talk about it? Yes No
Are there problems brewing because of the sexual problem? Yes No

What treatment plans have you heard about?

Psychological counseling	**Yes**	**No**
Penile implants	**Yes**	**No**
Hormone injections	**Yes**	**No**
Vacuum pumps	**Yes**	**No**
Urethral suppositories	**Yes**	**No**
Yohimbine	**Yes**	**No**

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

Have you ever been sexual abused? Yes No

Add any information that you believe to be helpful and fill out the other general information sheets.

Important note: Many insurances <u>DO NOT</u> cover expenses for treatment of sexual dysfunction. Please refer to you Benefit Guide under exclusions or call your insurance company for information regarding coverage. If your insurance does not provide coverage, <u>YOU</u> will be responsible for payment.