PATIENT INFORMATION

Last Name		First Name		MI	
Age		DOB		SSN	
Address (No PO Box)		City		State/Zip	
Home Phone		Cell		DL #	
Email		Employer		Occupation	
Date		Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed		

Do you have any of the following?

SKIN			LUNGS			SEXUAL DISEASE		
Bruise Easily	Y	N	Breathing Problems	Y	N	Genital Herpes	Y	N
Ulcers	Y	N	Emphysema	Y	N	Venereal Disease	Y	N
Tumors or Growths	Y	N	Asthma	Y	N	AIDS/HIV	Y	N
HEENT			NEUROLOGICAL			BONES OR JOINT		
Thyroid Disease	Y	N	Fainting Spells	Y	N	Swelling of limbs	Y	N
Glaucoma	Y	N	Seizures	Y	N	Rheumatism	Y	N
Frequent headaches	Y	N				Arthritis/Gout	Y	N
			BLOOD DISEASE					
HEART			Excessive Bleeding	Y	N	OTHER		
Cardiac Pacemaker	Y	N	Anemia	Y	N	Mental Illness	Y	N
Irregular Heart Beats	Y	N	Blood Transfusion	Y	N	Drug Addiction	Y	N
Chest Pain	Y	N	Sickle Cell Anemia	Y	N	Alcohol Abuse	Y	N
High Blood Pressure	Y	N	Diabetes	Y	N	Chemotherapy	Y	N
Low Blood Pressure	Y	N	Renal Dialysis	Y	N	Radiation Therapy	Y	N
Heart Attack	Y	N	Low Blood Sugar	Y	N	Kidney Problems	Y	N
			Hyperlipidemia	Y	N	Alzheimer's Disease	Y	N
Gastro Intestinal								
Hepatitis A	Y	N						
Recent Weight Loss	Y	N						
Liver Disease	Y	N						

Have you ever had any serious illness not listed above? ☐ Yes ☐ No Please explain: _____

_____

_____

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Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ NO KNOWN DRUG ALLERGIES

Any other allergies? _____

Are you under a Physician's or Surgeon's care now or in the last 2 years? ☐ Yes ☐ No

Physician Name _____ Office Phone _____

If yes, please explain: _____

What medications are you currently taking? _____

_____

Have you had surgery for prostate cancer? ☐ Yes ☐ No What year? _____ Where: _____

What type of surgical procedure did you have? ☐ Total Prostatectomy ☐ High-intensity Ultrasound ☐ Green Laser

Are you currently taking prostate cancer medications? (Sometimes called hormone therapy) ☐ Yes ☐ No

What prostate cancer medications are you taking? _____

Have you been hospitalized or had other major surgery in the past 5 years? ☐ Yes ☐ No

Please explain: _____

_____

Have you ever had a serious head, neck, back, and pelvis or penis injury? ☐ Yes ☐ No

Please explain: _____

_____

Do you have a special food diet? ☐ Yes ☐ No _____ Do you use any controlled substances? ☐ Yes ☐ No

Have you ever taken any weight loss medication like Redux or Phen-Fen? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ No

Although men's sexual health primarily treats the area in and around your penis, your sexual health is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Have you taken any Viagra, Cialis or Levitra in the last 48 hours? ☐ YES ☐ NO

Sexual History

☐ Erection problems:	Problem achieving	☐ Yes	☐ No	Problem maintaining	☐ Yes	☐ No
☐ Premature ejaculation:	Life-long problem	☐ Yes	☐ No	Recent onset	☐ Yes	☐ No

☐ Both

Erectile Dysfunction (ED)

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How long has it been an issue? _____

Are the erection problems: ☐ Improving ☐ Staying the same ☐ Becoming worse

Are the erection problems: ☐ Consistent ☐ Sporadic

Can you consistently achieve and maintain a full erection for sexual penetration? ☐ Yes ☐ No

Do you have problems controlling your ejaculation since the onset of ED? ☐ Yes ☐ No

Indicate the best erections achieved during sexual encounter, in the last 3-6 months:

- ☐ 50% (unable to penetrate)
- ☐ 65% (able to penetrate but with difficulty most of the time)
- ☐ 80% (able to penetrate fairly easily most of the time)
- ☐ 90% (almost complete)
- ☐ 100% (rock hard erection)

Do you experience morning erections? ☐ Yes ☐ No How many times a week? _____

Premature Ejaculation (PE)

- ☐ A lifelong problem that remains essentially the same
- ☐ A lifelong problem that becomes worse recently
- ☐ A recent problem. If so, how long? _____

Please elaborate on your experience: _____

_____

During foreplay, could you achieve and maintain a full erection until you ejaculate? ☐ Yes ☐ No

Do you ejaculate before penetration? ☐ Yes ☐ No

On average, how long does it take you to ejaculate after penetration? _____

What, in your opinion, has caused your problem? _____

What treatments options have you tried? _____

Indicate the positive and negative effects, if any: _____

What do you wish to accomplish from this visit? _____

_____