RWJ PHYSICIAN ENTERPRISE

SUA SOMERSET UROLOGICAL ASSOCIATES

Name: _____ Date of Birth: _____ Date: _____

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of responses that **best describe** your own situation. Please be sure that you select one and only one response for **each question.**

Over the Past 6 months:

1. How do you rate your confidence that you could get and keep an erection?

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering you partner)?

No Sexual Activity	Almost Never	A Few Times	Sometimes	Most of the Time	Almost Always
0	1	2	3	4	5

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

Did Not Attempt	Almost Never	A Few Times	Sometimes	Most of the Time	Almost Always
0	1	2	3	4	5

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

Did Not Attempt	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
0	1	2	3	4	5

5. When you attempted sexual intercourse, how often was it satisfactory for you?

No Sexual Activity	Almost Never	A Few Times	Sometimes	Most of the Time	Almost Always
0	1	2	3	4	5

SCORE:_____

Add the numbers corresponding to questions 1-5. If your score is 21 or less, you may want to speak with your doctor.

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Please circle the answer that best represents your response to each of the following questions. The questions are designed to gauge the severity of any symptoms you may be experiencing.

	Not At All	Less than 1in5	Less than 1/2	About 1/2	More than 1/2	Almost Always	Patient Score
Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
Frequency Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?	0	1	2	3	4	5	
Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining Over the past month, how often have you had to push to strain to begin urination?	0	1	2	3	4	5	
Nocturia Over the past month, how many times did you most typically get up to urinate from time to time when you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	
						Your Total Score:	

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
Quality of Life Due to Urinary Symptoms If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6