DR LOVE
UROLOGICAL SURGEON

ERECTILE DYSFUNCTION QUESTIONNAIRE

Dr Christopher Love
Urological Surgeon
M.B. B.S. F.R.A.C.S.
Provider No. 049428AL

CONTACT:
96604911
1800 DRLOVE
(1800 375 683)

chris@drlove.com.au
www.drlove.com.au

CONSULTING AT:
Urology South
Level 2,
Holmesglen Private
Hospital ,
490 South Rd.,
Moorabbin VIC 3189

Men's Health Melbourne
Level M 233 Collins St
Melbourne VIC 3000

SPECIALIST IN:
Penile Implant Surgery
Erectile Dysfunction
Peyronie's Disease
BPH Management
- Greenlight Laser
-Rezum
-UroLift
Penile Rehabilitation
Incontinence after Cancer
"No Scalpel" Vasectomy
Men's Health Advice
Stone Disease
General Urology

In order to understand the exact nature of your problem, we ask that you complete the questionnaire

Name: _____ Date of Birth: / /

Age: _____

Marital Status: _____

1. Do you have problems obtaining an erection, maintaining an erection or both?

   _____

2. When did you first notice a change in your sexual function

   (approximate year/month)? _____

3. Do you recall any significant events that occurred around the same time? Y N

   Marital/sexual partner problems Death in the family

   Loss of job Financial problems Illness or injury

Use this scale to describe the quality (grade) of your erections for questions 4 - 5

Grade 1 - penis is larger than normal, but not hard

Grade 2 - penis is hard, but not hard enough for penetration

Grade 3 - penis is hard enough for penetration but not completely hard,

Grade 4 - penis is completely hard and fully rigid.

4. Do you have an erection or semi-erection in the morning before you urinate?

   Y N

   How often: _____ Grade: _____

5. Do you ever awaken at night and notice an erection or semi erection? Y N

   How often: _____ Grade: _____

6. Do other types of stimulus improve your erections such as masturbation, oral sex, erotic films, reading material? Y N

7. Are your erections ever firm enough for vaginal penetration? Y N

8. Do you ever notice any increase or decrease in your erections with position changes? Y N

9. Are you concerned about the appearance of your penis such as:

☐Bend or curvature ☐ Lumps ☐ Loss of length

10. When was the last time you had successful intercourse? _____

11. Do you consider your desire for sex normal? Y N

12. Are you able to ejaculate? Y N
By what method: ☐ Intercourse ☐ Masturbation ☐ Oral sex
Does the semen: ☐ Spurt out ☐ Flow out slowly

13. Do you have premature ejaculation? Y N
If yes, occasionally or every time? ☐ Lifelong ☐ Recent onset

14. Have you noticed any change in the sensation of your penis? Y N
☐Decreased ☐ Increased ☐ Numbness Date first noticed change in sensation: _____

15. Has your problem with sexual dysfunction affected your relationship with your partner? Y N

16. Do you have a sexual partner at this time? Y N

17. In the past have you received treatment for erectile dysfunction Y N

If yes, please circle treatment type and dates of treatment

Treatment	*Date(s)*
Oral medication	
Vacuum device	
Testosterone patches or injections	
Urethral Pellet (MUSE) or gel	
Penile injections	
Surgery/implants	

Are you currently using medications prescribed for erectile dysfunction? Y N
If yes, what: _____

18. Do you have any problems with urination? Y N

If yes, please circle the problem(s) and frequency of problem(s)

Frequency during	☐ day ☐ evening
Urgency or leakage of urine:	rarely sometimes almost always
Difficulty starting stream:	rarely sometimes almost always

19. Are you taking any prescription medications including aspirin and vitamins? Y N
Please list all medications:

_____
_____
_____
_____

20. In the past, have you had major surgery? Y N

If so, please check those that apply and please indicate approximate dates of surgery:

Surgery	*Date(s)*
Back/spine	
Prostate	
Heart/blood vessels	
Penis	
Bowel	
Organ transplants	

21 Do you have problems with?

Shortness of breath or leg pain	*Y N*
Climbing 1 or 2 flights of stairs	*Y N*
Walking 5 or 6 blocks	*Y N*

22. Tobacco use: ☐ Never smoked ☐ Currently smoke ☐ Smoked in the past

If you smoke, how many per: Day Week Month _____

Have you quit? Y N If yes, when? _____

22. Alcohol consumption: do you currently consume alcoholic beverages? Y N

23. Have you consumed alcohol in the past? Y N

☐ Beer ☐ Wine ☐ Spirits

How much _____per day _____week

How long for ? _____When did you quit? _____

24. Do you have a history of depression? Y N

If yes, please explain: _____

Are you currently receiving therapy for your depression? Y N

Are you currently taking prescribed medication for depression? Y N

If yes, please list medication(s): _____

25. Do you have a history of other emotional or psychiatric problems? Y N If yes, please explain:

_____