DR. LOVE
UROLOGICAL SURGEON

Center of Excellence FOR PENILE IMPLANTS

ERECTILE DYSFUNCTION QUESTIONNAIRE

In order to help understand your problem, we ask that you complete this questionnaire

Name: _____ Date of Birth: / / Age: _____

Marital status: Single / Married / De Facto / Regular partner / Widowed

1. Do you have problems either:
   a. Getting an erection Y N Sometimes
   b. Keeping your erection Y N Sometimes
   c. Both getting and keeping an erection

2. When did you first notice a change in your erections (approximate month or year)? _____

3. Do you recall any events that occurred around the same time that may have contributed to the problem?
   a. Marital / relationship problems Y N
   b. Illness or surgery Y N
   c. Financial problems Y N
   d. Loss of job Y N
   e. Death in the family Y N

Use this scale to describe your erections in the following questions 4 , 5 & 6
Grade 1 - penis 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. What is the grade of your erections now ? (using the above scale): _____

5. Do you have an erection or semi-erection as you wake in the morning? Y N Sometimes
   a. How often? Most days / Every week or so
   b. Grade of erection (using the scale above): _____

6. Do you ever wake at night and notice an erection or semi-erection? Y N Sometimes
   a. How often? Most days / Every week or so
   b. Grade of erection (using the scale above): _____

7. Do other types of stimulus improve your erections? Things such as masturbation, oral sex, pornography?
   Y N Sometimes

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8. Are your erections firm enough for penetrative sex? Y N Sometimes

9. Do you ever notice any increase or decrease in your erections with posture changes?

Y N Sometimes
If so, what position is best? Standing up / Lying down/ Sitting

10. Are you concerned about the appearance of your penis such as:
Bend or curvature / Lumps / Loss of length

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

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

13. Are you able to ejaculate? Y N Sometimes

By what method: ☐ Intercourse ☐ Masturbation ☐ Oral sex
Does the semen: ☐ Spurt out ☐ Flow out slowly

14. Do you have premature ejaculation? Y N Sometimes

If yes, occasionally or every time? _____ ☐ Lifelong ☐ Recent onset

15. Have you noticed any change in the sensation of your penis? Y N Sometimes

☐Decreased ☐ Increased ☐ Numbness ☐ Pain

Date first noticed change in sensation: _____

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

17. Has your problem with erectile dysfunction affected your relationship with your partner?

Y N Sometimes

18. In the past have you been on any treatment for erectile dysfunction? Y N

If yes, please indicate treatment type and dates of treatment

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

19. Are you currently using medications prescribed for erectile dysfunction? Y N

If yes, what: _____

20. Do you have any problems with urination? Y N Sometimes

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

Frequency during ☐ day ☐ night

Urgency or leakage of urine:	rarely	sometimes	almost always
Difficulty starting stream:	rarely	sometimes	almost always

21. Are you taking any prescription medications, including aspirin and vitamins? Y N

Please list all medications:

_____

_____

_____

_____

_____

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

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

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

23. 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

24. 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?* _____

☐ Beer ☐ Wine ☐ Spirits

25. Alcohol consumption: do you currently consume alcoholic beverages? Y N
Have you consumed alcohol in the past? Y N

How much per: day week _____ ☐ Beer ☐ Wine ☐ Spirits

How long for ? _____When did you quit? _____

26. Do you have a history of anxiety / depression? Y N

If yes, please explain: _____

Are you currently receiving therapy for your anxiety /depression? Y N

Are you currently taking prescribed medication for anxiety /depression? Y N

If yes, please list medication(s): _____

27. Do you have a history of other emotional or psychiatric problems? Y N

If yes, please explain: _____