DR. LOVE
UROLOGICAL SURGEON

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 currently? (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

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

Phone: 03 9660 4911 or 1800 DR LOVE (1800 375 683)
Email: info@drlove.com.au
Fax: 03 9660 4919
Website: drlove.com.au

Urology South
Level 2, Holmesglen Private Hospital
490 South Road, Moorabbin VIC 3189
Melbourne CBD
Level M, 233 Collins Street
Melbourne VIC 3000

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 position changes?
Y N Sometimes
What position is best? _____

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 received 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: _____