PATIENT NAME:_____**DOB#**_____**DATE:**_____

CHIEF COMPLAINT: **ERECTILE DYSFUNTION**

ERECTIONS: ABSENT _____SHORT-LIVED _____NORMAL DURATION _____
RIGID _____ SEMI-RIGID _____ FLACCID _____

ERECTION QUALITY: - SCALE 1 – 10 _____ LAST VAGINAL PENETRATION _____

DURATION OF ERECTILE DYSFUNCTION: _____

AM ERECTIONS: _____YES _____ NO QUALITY: _____

ABLE TO EXPERIENCE ORGASM: _____YES _____ NO ABLE TO EXPERIENCE EJACULATION: _____ YES _____ NO

LIBIDO – NORMAL _____ DIMINISHED _____ ABSENT _____ PREMATURE EJACULATIONS: _____ YES _____ NO

ANY PRIOR TREATMENT:_____

PAST MEDICAL HISTORY:

HTN: _____ YES _____ NO D.M. _____ YES _____ NO
HYPERCHOLESTEROLEMIA: _____ YES _____ NO PELVIC SURGERY: _____ YES _____ NO
ETOH ABUSE: _____ YES _____ NO TOBACCO: _____ PACK/YEARS

REVIEW OF SYSTEMS:

HOT FLASHES: _____ YES _____ NO DIPLOPIA: _____ YES _____ NO
NUMBNESS/TINGLING IN LEGS OR GENITALIA: _____ YES _____ NO

_____ Patient verbalizes understanding of instructions given

Provider Signature: _____ Date: _____ Time: _____

Patient Name:

Date of Birth: