

THE UROLOGY GROUP

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Name _____ Date of birth _____ Today's date _____

ED EVALUATION

Sexual Health History

How long has this problem been going on? _____ Have you had any treatment for it? _____
Ever have normal erections? _____ When was last _____ Erections adequate for sex? _____
Morning or night time erections? _____ Normal desire (sex drive, libido)? _____ Normal orgasm? _____
Normal ejaculation? _____ Bend or curvature of penis? (Peyronie's disease) _____

Relationship History Recent stress (divorce, job loss, new relationship)? _____
Do you have a partner or spouse? _____ Relationship problems? _____

Medical History

High blood pressure? _____ Medication for high blood pressure? _____
Diabetes? _____ Insulin use? _____ High cholesterol _____ Medication for cholesterol? _____
Has your doctor told you to lose weight? _____ Calves hurt with walking? _____ Heart attack? _____
Coronary artery disease? _____ Bypass surgery? _____ Stroke? _____
Carotid artery disease? _____ Vascular surgery? _____ Neurologic problem? _____

Surgical History

Prostate surgery (surgery, date)? _____ Bladder surgery (surgery, date)? _____
Colon/rectum surgery (surgery, date)? _____ Other pelvic surgery (surgery, date)? _____
Injury the pelvis, groin or penis? (injury, date)? _____

Social History

Smoking history? _____ How many packs a day? _____ How many years have you smoked? _____
Current smoker? _____ When did you quit? _____ Alcohol use? _____ Drug use (marijuana, steroids)? _____

Medications Do you take thiazide diuretic (eg HCTZ)? _____ Beta blocker (eg metoprolol)? _____
(except nebivolol)