THE UROLOGY GROUP

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Name ________________________________ Date of birth ______________ Today's date _______________

ERECTION 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?__________

Nighttime/morning erections? ______ Normal desire (sex drive, libido)?_______ Normal orgasm?______

Normal ejaculation?_________________ Bend or curvature of penis? (Pyeronie'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 aack?_______

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)?_____
chronic prescription pain medicine _____

Medications

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

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