THE STRIPLING CENTER – SEXUAL HEALTH QUESTIONAIRE

Patient Name:____

1) How long have you had this condition?

2) Since the symptoms started has the condition...

Remained the same ☐ Improved ☐ Worsened ☐

3) Are you able to have nocturnal erections?

Always ☐ Almost Always ☐ Half of the Time ☐ Almost Never ☐ Never ☐

4) Do you have difficulty obtaining erections? YES ☐ NO ☐

5) Do you have difficulty maintaining erections? YES ☐ NO ☐

6) How often is your erection sufficient for penetration?

Always ☐ Almost Always ☐ Half of the Time ☐ Almost Never ☐ Never ☐

7) How often does ejaculation occur before penetration?

Always ☐ Almost Always ☐ Half of the Time ☐ Almost Never ☐ Never ☐

8) How often does ejaculation occur within 2 minutes of penetration?

Always ☐ Almost Always ☐ Half of the Time ☐ Almost Never ☐ Never ☐

9) Describe your Libido....

Do you have a decrease in libido (sex drive)	Yes	No
Do you have a lack of energy	Yes	No
Do you have a decrease in strength, endurance, or both	Yes	No
Have you lost height	Yes	No
Have you noticed a decreased enjoyment of life	Yes	No
Are you sad, grumpy or both	Yes	No
Are your erections less strong	Yes	No
Have you noticed a deterioration in your ability to play sports	Yes	No
Are you falling asleep after dinner	Yes	No
Has there been a deterioration in your work performance	Yes	No

10) If previously seen for this problem, what treatment was done? ie, medications, injections, etc.

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11) Do you have a history of Prostate Cancer? If yes, state treatment.
YES ☐ NO ☐

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12) State any other associated medical conditions, ie. Diabetes, Hypertension, Smoking, etc.

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