

Affix patient label here

Date:

## Department of Urology

This questionnaire is designed to help your urologist to find out if you are experiencing any erectile dysfunction and if so, how severe it is. Each question has several responses, please circle the number of the response that best describes your own situation. Please only select one response per question. You may be asked to complete this form at subsequent visits in order to reassess your symptoms at that time.

**Over the past six months:**

1. How do you rate your <b>confidence</b> that you could get and keep an erection?		Very low <b>1</b>	Low <b>2</b>	Moderate <b>3</b>	High <b>4</b>	Very high <b>5</b>
2. When you had erections with sexual stimulation, <b>how often</b> were your erections hard enough for penetration (entering your partner)?	No sexual activity <b>0</b>	Almost never or never <b>1</b>	A few times (much less than half the time) <b>2</b>	Sometimes (about half the time) <b>3</b>	Most times (much more than half the time) <b>4</b>	Almost always or always <b>5</b>
3. When you had an erection <b>how often</b> were you able to maintain your erection after you had penetrated your partner?	Did not attempt intercourse <b>0</b>	Almost never or never <b>1</b>	a few times (much less than half the time) <b>2</b>	Sometimes (about half the time) <b>3</b>	Most times (much more than half the time) <b>4</b>	Almost always or always <b>5</b>
4. During sexual intercourse <b>how difficult</b> was it to maintain your erection to completion of intercourse?	Did not attempt intercourse <b>0</b>	Extremely difficult <b>1</b>	Very difficult <b>2</b>	Difficult <b>3</b>	Slightly difficult <b>4</b>	Not difficult <b>5</b>
5. When you attempted sexual intercourse, <b>how often</b> was it satisfactory for you?	Did not attempt intercourse <b>0</b>	Almost never or never <b>1</b>	A few times (much less than half the time) <b>2</b>	Sometimes (about half the time) <b>3</b>	Most times (much more than half the time) <b>4</b>	Almost always or always <b>5</b>
<b>Add up your total score and write it in the box.</b>					<b>Total</b>	

**Quality of life due to loss of sexual function**

If you were to spend the rest of your life with your condition the way it is today how would you feel about that? (Please tick which best describes how you would feel.)

- Delighted  0
- Pleased  1
- Mostly Satisfied  2
- Mixed - about equally satisfied and dissatisfied  3
- Mostly dissatisfied  4
- Unhappy  5
- Terrible  6

**Are you taking any medication to help you with your erections?**

- Yes  No

If yes, please give details below:

*To be completed by clinician*

**Type of Treatment**

- Radical retropubic prostatectomy  
 Radical laporoscopic prostatectomy

- EBRT  
 Brachytherapy

**Clinician:**

- CAC  
 MES  
 Other

- Batnaghar

**Timing of appointment:**

- Pre-treatment  
 3 Months Post treatment  
 6 Months Post treatment  
 12 Months Post treatment  
 >12 months Post treatment  
 Discharged at this appointment

**ED Clinic**

**Type of treatment**

- PDE5  
 Caverject  
 Vacuum pump  
 Other

**Consultant:**

- MCD  
 PJG  
 GSM  
 CAC  
 MES  
 SpR

**Timing of appointment:**

- Pre treatment  
 3 Months Post treatment  
 6 Months Post treatment  
 12 Months Post treatment  
 >12 months Post treatment  
 Discharged at this appointment