MEN'S MEDICAL NEW YORK, P.C.

PATIENT INFORMATION & QUESTIONNAIRE

Date_____

Patient Name_____ DOB_____

Address_____City_____State_____Zip Code_____

HOME PHONE_____ CELL PHONE_____

Occupation_____ Marital Status: S M D W

Email address_____

How did you hear about our practice _____

Medical History – Please circle any that you have or have ever had

Diabetes	High Blood Pressure	High Cholesterol	Heart Disease	Heart attack
Liver disease	Hepatitis	Kidney disease	Thyroid disease	Stroke
HIV/AIDS	Multiple sclerosis	Parkinson's disease	Peyronie's disease	Epilepsy
Cancer	Prostate cancer	Sickle cell disease	Priapism	Glaucoma
Depression	Bleeding disorders	Testicular disease	Arthritis	STD's
Infertility	Ejaculation problems	Trauma/accident	Prostate enlargement	Prostatitis
Back surgery	Drug abuse	Mental disorder	Sexual abuse	

Surgical History – please list any surgery that you have ever had

_____

Social History

Do you smoke? Yes No Packs per day _____ Years you have smoked_____

Do you drink alcohol? Yes No Drinks per day_____ Drinks per week_____

Do you use heroin, cocaine, barbiturates, anabolic steroids, crack or other illicit drugs? Yes No
Describe_____

Medications – please list all prescription medication & supplements you are currently taking

_____

_____

_____

Referring physician or primary care physician – name, address and phone number

_____

_____

Reason for today's visit – please circle

Erectile Dysfunction Premature Ejaculation Other_____

Do you believe your problem is related to a recent motor vehicle accident? YES NO

Sexual history

Describe the strength of you erections from 1 – 10? _____

Out of the last 10 times you attempted to have intercourse, how many were successful? _____

Describe the strength of you morning erections from 1 – 10? _____

When did you first notice a problem with your erections? _____

What do you think is causing your erection problem? _____

When was the last time you had a great erection that allowed penetration? _____

Can you achieve and maintain a full erection until you ejaculate? Yes No

Can you achieve a good erection through masturbation? Yes No

Can you have an orgasm? Yes No

Can you ejaculate when you have an orgasm? Yes No

Do you have any pain when you have an orgasm or ejaculation? Yes No

How often do you attempt sexual intercourse with your partner? _____

How often do you masturbate? _____

How long does it take you to ejaculate after penetration? _____

What medications have you tried for erectile dysfunction? _____

What medications have you tried for ejaculation problems? _____