Name: _____ Date: _____

SAN DIEGO SEXUAL MEDICINE

INTERNATIONAL INDEX OF ERECTILE FUNCTION (IIEF)

These questions ask about the effects that your erection problems have had on your sex life over the last four weeks. Please try to answer the questions as honestly and as clearly as you are able. Your answers will help your doctor to choose the most effective treatment suited to your condition. In answering the questions, the following definitions apply:

- **sexual activity** includes intercourse, caressing, foreplay & masturbation
- **sexual intercourse** is defined as sexual penetration of your partner
- **sexual stimulation** includes situation such as foreplay, erotic pictures etc.
- **ejaculation** is the ejection of semen from the penis (or the feeling of this)
- **orgasm** is the fulfilment or climax following sexual stimulation or intercourse

Over the past 4 weeks:
Please check one box only

1. How often were you able to get an erection during sexual activity?
   - c 0 No sexual activity
   - c 1 Almost never or never
   - c 2 A few times (less than half the time)
   - c 3 Sometimes (about half the time)
   - c 4 Most times (more than half the time)
   - c 5 Almost always or always

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?
   - c 0 No sexual activity
   - c 1 Almost never or never
   - c 2 A few times (less than half the time)
   - c 3 Sometimes (about half the time)
   - c 4 Most times (more than half the time)
   - c 5 Almost always or always

3. When you attempted intercourse, how often were you able to penetrate (enter) your partner?
   - c 0 Did not attempt intercourse
   - c 1 Almost never or never
   - c 2 A few times (less than half the time)
   - c 3 Sometimes (about half the time)
   - c 4 Most times (more than half the time)
   - c 5 Almost always or always

4. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?
   - c 0 Did not attempt intercourse
   - c 1 Almost never or never
   - c 2 A few times (less than half the time)
   - c 3 Sometimes (about half the time)
   - c 4 Most times (more than half the time)
   - c 5 Almost always or always

Name: _____ Date: _____

5. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?
- c 0 Did not attempt intercourse
- c 1 Extremely difficult
- c 2 Very difficult
- c 3 Difficult
- c 4 Slightly difficult
- c 5 Not difficult

6. How many times have you attempted sexual intercourse?
- c 0 No attempts
- c 1 One to two attempts
- c 2 Three to four attempts
- c 3 Five to six attempts
- c 4 Seven to ten attempts
- c 5 Eleven or more attempts

7. When you attempted sexual intercourse, how often was it satisfactory for you?
- c 0 Did not attempt intercourse
- c 1 Almost never or never
- c 2 A few times (less than half the time)
- c 3 Sometimes (about half the time)
- c 4 Most times (more than half the time)
- c 5 Almost always or always

8. How much have you enjoyed sexual intercourse?
- c 0 No intercourse
- c 1 No enjoyment at all
- c 2 Not very enjoyable
- c 3 Fairly enjoyable
- c 4 Highly enjoyable
- c 5 Very highly enjoyable

9. When you had sexual stimulation or intercourse, how often did you ejaculate?
- c 0 No sexual stimulation or intercourse
- c 1 Almost never or never
- c 2 A few times (less than half the time)
- c 3 Sometimes (about half the time)
- c 4 Most times (more than half the time)
- c 5 Almost always or always

10. When you had sexual stimulation or intercourse, how often did you have the feeling of orgasm or climax?
- c 1 Almost never or never
- c 2 A few times (less than half the time)
- c 3 Sometimes (about half the time)
- c 4 Most times (more than half the time)
- c 5 Almost always or always

11.How often have you felt sexual desire?
- c 1 Almost never or never
- c 2 A few times (less than half the time)
- c 3 Sometimes (about half the time)

- c 4 Most times (more than half the time)
- c 5 Almost always or always

12. How would you rate your level of sexual desire?
    - c 1 Very low or none at all
    - c 2 Low
    - c 3 Moderate
    - c 4 High
    - c 5 Very high

13. How satisfied have you been with your overall sex life?
    - c 1 Very dissatisfied
    - c 2 Moderately dissatisfied
    - c 3 Equally satisfied & dissatisfied
    - c 4 Moderately satisfied
    - c 5 Very satisfied

14. How satisfied have you been with your sexual relationship with your partner?
    - c 1 Very dissatisfied
    - c 2 Moderately dissatisfied
    - c 3 Equally satisfied & dissatisfied
    - c 4 Moderately satisfied
    - c 5 Very satisfied

15. How do you rate your confidence that you could get and keep an erection?
    - c 1 Very low
    - c 2 Low
    - c 3 Moderate
    - c 4 High
    - c 5 Very high

Name: ________________________________ Date: __________________

Name: _____ Date: _____

SAN DIEGO SEXUAL MEDICINE

SEXUAL DISTRESS SCALE-REVISED

Below is a list of feelings and problems that men and women sometimes have concerning their sexuality. Please read each item carefully, and check the box that best describes how often that problem has bothered you or caused distress **over the last 4 weeks**. Please check only one box for each item, and take care not to skip ANY items.

Please check one box per question.

1. How often did you feel **distressed about your sex life**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

2. How often did you feel **unhappy about your sexual relationship**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

3. How often did you feel **guilty about your sexual difficulties**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

4. How often did you feel **frustrated by your sexual problems**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

5. How often did you feel **stressed about sex**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

6. How often did you feel **inferior because of sexual problems**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

Name: _____ Date: _____

7. How often did you feel **worried about sex**?
- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Occasionally
- ☐ 3 Frequently
- ☐ 4 Always

8. How often did you feel **sexually inadequate**?
- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Occasionally
- ☐ 3 Frequently
- ☐ 4 Always

9. How often did you feel **regrets about your sexuality**?
- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Occasionally
- ☐ 3 Frequently
- ☐ 4 Always

10. How often did you feel **embarrassed about sexual problems**?
- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Occasionally
- ☐ 3 Frequently
- ☐ 4 Always

11. How often did you feel **dissatisfied with your sex life**?
- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Occasionally
- ☐ 3 Frequently
- ☐ 4 Always

12. How often did you feel **angry about your sex**?
- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Occasionally
- ☐ 3 Frequently
- ☐ 4 Always

13. How often did you feel **bothered by low desire?**
- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Occasionally
- ☐ 3 Frequently
- ☐ 4 Always

Name: _____ Date: _____

PERCEIVED STRESS SCALE

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate *how often* you felt or thought a certain way by checking the box next to it.

1. In the last month, how often have you been upset because of something that happened unexpectedly?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

2. In the last month, how often have you felt that you were unable to control the important things in your life?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

3. In the last month, how often have you felt nervous and "stressed"?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

4. In the last month, how often have you felt confident about your ability to handle your personal problems?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

5. In the last month, how often have you felt that things were going your way?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

6. In the last month, how often have you found that you could not cope with all the things that you had to do?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

7. In the last month, how often have you been able to control irritations in your life?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

8. In the last month, how often have you felt that you were on top of things?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes

Name: _____ Date: _____

- ☐ 3 Fairly often
- ☐ 4 Very often

9. In the last month, how often have you been angered because of things that were outside of your control?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

Name: _____ Date: _____

SAN DIEGO SEXUAL MEDICINE

McGILL PAIN QUESTIONNAIRE FOR GENITAL PAIN

Please complete all questions regardless of presence or absence of genital pain.

1. Please check in the appropriate column the degree to which you experienced each type of pain in your genital.

	NONE	MILD	MODERATE	SEVERE
THROBBING	☐ 0	☐ 1	☐ 2	☐ 3
SHOOTING	☐ 0	☐ 1	☐ 2	☐ 3
STABBING	☐ 0	☐ 1	☐ 2	☐ 3
SHARP	☐ 0	☐ 1	☐ 2	☐ 3
CRAMPING	☐ 0	☐ 1	☐ 2	☐ 3
GNAWING	☐ 0	☐ 1	☐ 2	☐ 3
HOT-BURNING	☐ 0	☐ 1	☐ 2	☐ 3
ACHING	☐ 0	☐ 1	☐ 2	☐ 3
HEAVY	☐ 0	☐ 1	☐ 2	☐ 3
TENDER	☐ 0	☐ 1	☐ 2	☐ 3
SPLITTING	☐ 0	☐ 1	☐ 2	☐ 3
TIRING-EXHAUSTING	☐ 0	☐ 1	☐ 2	☐ 3
SICKENING	☐ 0	☐ 1	☐ 2	☐ 3
FEARFUL	☐ 0	☐ 1	☐ 2	☐ 3
PUNISHING-CRUEL	☐ 0	☐ 1	☐ 2	☐ 3

2. Please tick along scale below to rate severity of pain.

NO PAIN ☐----------☐ WORST PAIN

3. Please check in appropriate columns the overall intensity of pain.

PPI

- ☐ 0 NO PAIN
- ☐ 1 MILD
- ☐ 2 DISCOMFORTING
- ☐ 3 DISTRESSING
- ☐ 4 HORRIBLE
- ☐ 5 EXCRUCIATING

Name: _____ Date: _____

Personal Health Questionnaire

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and choose your response.

a. Little interest or pleasure in doing things
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

b. Feeling down, depressed or hopeless
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

c. Trouble falling asleep, staying asleep, or sleeping too much
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

d. Feeling tired or having little energy
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

e. Poor appetite or overeating
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

f. Feeling bad about yourself, feeling that you are a failure, or feeling that you let yourself or your family down
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

g. Trouble concentrating on things such as reading the newspaper or watching television
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

i. Thinking that you would be better off dead or that you want to hurt yourself in some way
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
- c 0 Not difficult at all
- c 1 Somewhat difficult
- c 2 Very difficult
- c 3 Extremely difficult

Name: _____ Date: _____

SAN DIEGO SEXUAL MEDICINE

Harder Personal Feelings Questionnaire (PFQ2)

For each of the following listed feeling, to the left of the item number, please place a number from 0 to 4, reflecting how common the feeling is for you.

4 = Continuously or almost continuously
3 = Frequently but not continuously
2 = Some of the time
1 = Rarely
0 = Never

☐ 1. Embarrassment
☐ 2. Mild guilt
☐ 3. Feeling ridiculous
☐ 4. Worry about hurting or injuring someone
☐ 5. Sadness
☐ 6. Self-consciousness
☐ 7. Feeling humiliated
☐ 8. Intense guilt
☐ 9. Euphoria
☐ 10. Feeling "stupid"
☐ 11. Regret
☐ 12. Feeling "childish"
☐ 13. Mild happiness
☐ 14. Feeling helpless, paralyzed
☐ 15. Depression
☐ 16. Feelings of blushing
☐ 17. Feeling you deserve criticism for what you did
☐ 18. Feeling laughable
☐ 19. Rage
☐ 20. Enjoyment
☐ 21. Feeling disgusting to others
☐ 22. Remorse

Name: _____ Date: _____

Revised 08/03/2009 Harder, Rockart & Cutler 1993

SAN DIEGO SEXUAL MEDICINE

NIH-Chronic Prostatitis Symptom Index (NIH-CPSI)

Pain or discomfort

1. In the last week have you experienced any pain or discomfort in the following areas?

	Yes	No
a. Area between rectum and testicles (perineum)	☐ 1	☐ 0
b. Testicles	☐ 1	☐ 0
c. Tip of the penis (not related to urination)	☐ 1	☐ 0
d. Below your waist, in your pubic or bladder area	☐ 1	☐ 0

2. In the last week have you experienced:

	Yes	No
a. Pain or burning during urination?	☐ 1	☐ 0
b. Pain or discomfort during or after sexual climax (ejaculation)?	☐ 1	☐ 0

3. How often have you had pain or discomfort in any of these areas over the last week?

- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Sometimes
- ☐ 3 Often
- ☐ 4 Usually
- ☐ 5 Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

no pain — pain as bad as you can imagine

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

- ☐ 0 Not at all
- ☐ 1 Less than 1 time in 5
- ☐ 2 Less than half the time
- ☐ 3 About half the time
- ☐ 4 More than half the time
- ☐ 5 Almost always

Name: _____ Date: _____

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

- ☐ 0 Not at all
- ☐ 1 Less than 1 time in 5
- ☐ 2 Less than half the time
- ☐ 3 About half the time
- ☐ 4 More than half the time
- ☐ 5 Almost always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

- ☐ 0 None
- ☐ 1 Only a little
- ☐ 2 Some
- ☐ 3 A lot

8. How much did you think about your symptoms, over the last week?

- ☐ 0 None
- ☐ 1 Only a little
- ☐ 2 Some
- ☐ 3 A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

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