New Patient Survey For Patients Visiting Alliance Urology for ED

Clinic - (336)274-1114

Name: _____Date of Birth:_____

1) How long have you been having difficulties with your erections? (Please write a number and circle years or months)

__ years / months

2) Have you tried any interventions to help improve your erections? (ex. oral medications, penile injections, vacuum device...)

Yes / No
If yes, please list: _____

3) Were these treatments effective when you first tried them? Circle yes or no. Please leave blank if you answered 'no' to the previous questions and have not tried anything to improve your erections yet.

Yes / No

4) Are any of these interventions still working for you currently? Why or why not?

Yes / No
Explain: _____

5) Would you say you have greatest difficulty with ACHIEVING an erection, MAINTAINING an erection, or BOTH?

Achieving / Maintaining / Both

6) If you had to rank the rigidity of your average erection (without medication) from 0-10 with 0 being no erection and 10 being the most rigid erection you've ever had, what ranking would you give?

___ (out of 10)

7) Is this erection sufficient for penetration?

Yes / No

8) Do you still experience erections in the middle of the night or when you wake up in the morning?

Yes / No

9) Have you noticed a curvature to your erections that wasn't present when you were younger?

Yes / No

Please complete all 2 pages of this document. Thank you.