SEXUAL FUNCTIONING AND HISTORY ASSESSMENT

Date ____/____/____
Name _____ Age _____ Social Sec. #_____
Referring health care provider name / address:
_____

Do you have a gynecologist who you have seen in the last 5 years?
_____

Gynecologist name and number:
_____

Primary care physician name and number:
_____

May we send correspondence regarding your visit and care to your Primary Care Physician?
Yes No

May we send correspondence regarding your visit and care to your Referring Physician?
Yes No

1. What bothers you most about your sexual functioning?
   _____
   _____
   _____
   _____
2. List any medications you are allergic to.
   _____
   _____
   _____
3. List any medications you are currently taking.
   _____
   _____
   _____
4. List any medical conditions that are currently or have been treated for in the past.
   _____
   _____
   _____
5. Do you have any of the following medical conditions: *(circle any that apply)*

a. Diabetes Mellitus	b. Thyroid disease	c. Pernicious anemia
d. Paralysis	e. Stroke	f. Multiple Sclerosis
g. Parkinson's Disease	h. Back or Brain surgery	i. Fibromyalgia
j. Blood clots in legs/lungs	k. Chronic cough	l. Smoking
m. Pacemaker	n. Heart failure	o. Weight problems
p. Glaucoma	q. Other_____	

6. Date of last menstrual period: _____
7. Date of last pap smear: _____
8. Have you had any abnormal pap smears? _____

9. What form of contraception are you using? _____
10. How many pregnancies have you had? _____
11. How many vaginal deliveries have you had? _____
12. How many cesarean sections have you had? _____
13. Were forceps used for any of your deliveries? _____
14. Did you have an episiotomy for any of your deliveries? _____
15. What was the birth weight of your largest baby? _____
16. When was your last childbirth? _____
17. Are you menopausal? **Yes** **No**
If so, have you ever taken hormones? **Yes** **No**
Are you currently taking hormones? **Yes** **No**
18. If you had previously taken hormones, but are not now, when did you stop taking them?
_____
19. If you had previously taken hormones, but are not now, why did you stop taking them?
_____
20. Have you had any bleeding or spotting since menopause? _____
21. Marital status: Single Married Divorced Widowed
22. Do you smoke? _____
a. If yes: How many daily: _____
23. Do you drink alcohol?
a. If yes, how many drinks do you have daily?
24. Have you recently had an increase in fatigue?
25. Have you recently had changes in: Sleep Appetite Moods Weight
26. Do you exercise regularly? ……**Yes** **No**
27. What is your occupation? _____
28. What is your home life like/relationships? _____
29. Are you experiencing any sexual violence or abuse? _____
30. Do you have any other stresses in your life? _____
31. Are you experiencing physical abuse? _____
32. Are you experiencing mental abuse? _____
33. Does your partner have any problems with erectile dysfunction? **Yes** **No**
34. Do you have sex with men, women, or both? _____
35. Have you had any of the following operations/procedures?

Surgery/Procedure	**Year**	**Reason for the surgery/procedure**
Removal of the uterus		
Removal of the ovaries		
Bladder surgery		
Brain/Back surgery		
Cystoscopy		
Urodynamic study		
Urethral dilation		
Other		

The following questions ask about your sexual feelings and responses during the past four weeks. Please answer the questions honestly and clearly as possible. In answering these questions the following definitions apply:

Sexual Activity: can include caressing, foreplay, masturbation, and vaginal intercourse.
Sexual Intercourse: is defined as penile penetration (entry of the vagina)
Sexual stimulation: includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

Please check only one circle per question

Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

1. Over the past 4 weeks, how often did you feel sexual desire or interest?
    - o Almost always or always
    - o Most times (more than ½ of the time)
    - o Sometimes (about ½ of the time)
    - o A few times (less than ½ of the time)
    - o Almost never or never

2. Over the past 4 weeks, how would you rate your level (degree) of sexual desire or interest?
    - o Very high
    - o High
    - o Moderate
    - o Low
    - o Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscles contractions.

3. Over the past 4 weeks, how often did you feel sexually aroused during sexual activity or intercourse?
    - o No sexual activity
    - o Almost always or always
    - o Most times (more than ½ of the time)
    - o Sometimes (about ½ of the time)
    - o A few times (less than ½ of the time)
    - o Almost never or never

4. Over the past 4 weeks, how would you rate your level of sexual arousal?
    - o No sexual activity
    - o Very high
    - o High
    - o Moderate
    - o Low
    - o Very low or none at all

5. Over the past 4 weeks, how confident were you about becoming sexually aroused during sexual activity or intercourse?
    - No Sexual Activity
    - Very high
    - High
    - Moderate
    - Low
    - Very low or none at all

6. Over the past 4 weeks, how often have you been satisfied with your arousal during sexual activity or intercourse?
    - No sexual activity
    - Almost always or always
    - Most times (more than ½ of the time)
    - Sometimes (about ½ of the time)
    - A few times (less than ½ of the time)
    - Almost never or never

7. Over the past 4 weeks, how often did you become lubricated during sexual activity or intercourse?
    - No sexual activity
    - Almost always or always
    - Most times (more than ½ of the time)
    - Sometimes (about ½ of the time)
    - A few times (less than ½ of the time)
    - Almost never or never

8. Over the past 4 weeks, how difficult was it to become lubricated during sexual activity or intercourse?
    - No sexual activity
    - Extremely difficult or impossible
    - Very difficult
    - Difficult
    - Slightly difficult
    - Not difficult

9. Over the past 4 weeks, how often did you maintain your lubrication until completion of sexual activity or intercourse?
    - No sexual activity
    - Almost always or always
    - Most times (more than ½ of the time)
    - Sometimes (about ½ of the time)
    - A few times (less than ½ of the time)
    - Almost never or never

10. Over the past 4 weeks, how difficult was it to maintain your lubrication until completion of sexual activity or intercourse?
    - No sexual activity
    - Extremely difficult or impossible
    - Very difficult
    - Difficult
    - Slightly difficult
    - Not difficult

11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how often did you reach orgasm?
    - No sexual activity
    - Almost always or always
    - Most times (more than ½ of the time)
    - Sometimes (about ½ of the time)
    - A few times (less than ½ of the time)
    - Almost never or never

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how difficult was it for you to reach orgasm?
    - No sexual activity
    - Extremely difficult or impossible
    - Very difficult
    - Difficult
    - Slightly difficult
    - Not difficult

13. Over the past 4 weeks, how satisfied were you with your ability to reach orgasm during sexual activity or intercourse?
    - No sexual activity
    - Very satisfied
    - Moderately satisfied
    - About equally satisfied and dissatisfied
    - Moderately dissatisfied
    - Very dissatisfied

14. Over the past 4 weeks, how satisfied have you been with the amount of emotional closeness during sexual activity between you and your partner/
    - No sexual activity
    - Very satisfied
    - Moderately satisfied
    - About equally satisfied and dissatisfied
    - Moderately dissatisfied
    - Very dissatisfied

15. Over the past 4 weeks, how satisfied have you been with your sexual relationship with your partner?
    - Very satisfied
    - Moderately satisfied
    - About equally satisfied and dissatisfied
    - Moderately dissatisfied
    - Very dissatisfied

16. Over the past 4 weeks, how satisfied have you been with your overall sexual life?
    - Very satisfied
    - Moderately satisfied
    - About equally satisfied and dissatisfied
    - Moderately dissatisfied
    - Very dissatisfied

17. Over the past 4 weeks, how often did you experience discomfort or pain during vaginal penetration?
    - Did not attempt intercourse
    - Almost always or always
    - Most times (more than ½ of the time)
    - Sometimes (about ½ of the time)
    - A few times (less than ½ of the time)
    - Almost never or never

18. Over the past 4 weeks, how often did you experience discomfort or pain following vaginal penetration?
    - Did not attempt intercourse
    - Almost always or always
    - Most times (more than ½ of the time)
    - Sometimes (about ½ of the time)
    - A few times (less than ½ of the time)
    - Almost never or never

19. Over the past 4 weeks, how would you rate your level of discomfort or pain during or following vaginal penetration?
    - Did not attempt intercourse
    - Very high
    - High
    - Moderate
    - Low
    - Very low/none at all

20. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

21. 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?

Not difficult at all	Somewhat difficult	Very difficult	Extremely Difficult
☐	☐	☐	☐

Thank you for taking the time to fill out this questionnaire.