We would like to confirm the new patient appointment with Megan Merrill, DO and scheduled as follows:

Date:

Time:

Location: 1st Floor Clinic – Department of GU Oncology
300 West 10th Ave
Columbus, Ohio 43210

Please have your current insurance card(s) available when you register. It is recommended that you call your insurance carrier to confirm your benefits. If your insurance carrier requires prior authorization and/or a primary care physician referral, you are responsible for taking care of these matters prior to your visit. Please note co-payments are expected at the time of service or you will be rescheduled. We accept cash, check, or debit/credit cards.

We request that you make arrangements to bring all of your medication (prescription and non-prescription) bottles with you, recent radiology disc, and pertinent medical records such as: radiology reports, lab and pathology results, pulmonary and cardiac testing, and operative reports.

Please arrive 30 minutes prior to your appointment time to complete the registration process and clinic assessment. We have enclosed directions for your convenience.

If you have any questions, please feel free to contact our office at 614-293-4885 or 614-685-4263.

Sincerely,

Department of Urology Oncology
Wexner Medical Center and The James Cancer Hospital
Dr. Merrill Patient History Form

READ AND COMPLETE BEFORE YOUR VISIT!

1) FILL OUT THIS FORM completely, and bring it with you. Even better — fax or e-mail it before your appointment.

   Fax: (614) 685-4768

   E-Mail: amy.filippi@osumc.edu

2) BRING ALL OF YOUR MEDICATIONS WITH YOU IN THEIR BOTTLES. This includes tablets, liquids, patches, inhalers, eye drops, injections, nonprescription (over-the-counter), vitamins, herbs, pills, and creams. Extended care facility residents should bring their current Medication Administration Record, NOT just a list of orders.

3) BRING, FAX, OR E-MAIL RECENT MEDICAL REPORTS: including most recent office notes, surgery reports, pathology reports, radiology reports and disc, EKG, stress test, heart echo, heart catheterization, breathing tests (PFTs, spirometry), and hospital discharge summaries. See above for fax number and/or e-mail address. You should be able to obtain these from your urologist, family doctor, the doctor who did the test, or the hospital where the test was done. Please list the complete names and telephone numbers of your doctors so that we may contact them. You do not need to obtain reports of tests done at The Ohio State Wexner Medical Center locations. We have access to those reports.
# Department of Urology

**MEDICAL & FAMILY HISTORY. Please DO NOT MAIL these forms. BRING THEM when you come for your appointment.**

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>M</th>
<th>SEX</th>
<th>F</th>
<th>DATE OF BIRTH</th>
<th>BIRTHPLACE</th>
<th>NATIONALITY</th>
<th>MAN #</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
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<tr>
<th>OCCUPATION</th>
<th>RELIGION</th>
<th>HEALTH OF SPOUSE</th>
<th>EDUCATION THROUGH GRADE</th>
<th>EXERCISE</th>
<th>ADD TO SLEEP</th>
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<tbody>
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<tr>
<th>ALCOHOL/DAY</th>
<th>TYPE</th>
<th>TABACCO/DAY</th>
<th>TYPE</th>
<th>TEA (CUPS/DAY)</th>
<th>COFFEE (CUPS/DAY)</th>
<th>DRUG USES (TYPE AND FREQUENCY)</th>
</tr>
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<tbody>
<tr>
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**MEDICATIONS**

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<tr>
<th>INDICATION</th>
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<th>Frequency</th>
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**HOSPITALIZATIONS**

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<tr>
<th>DISCHARGE</th>
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<th>DISCHARGE</th>
<th>YEAR</th>
<th>DISCHARGE</th>
<th>YEAR</th>
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<tbody>
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**FAMILY HISTORY**

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<tr>
<th>Condition (N or Y)</th>
<th>Y</th>
<th>N</th>
<th>Condition (N or Y)</th>
<th>Y</th>
<th>N</th>
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</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>N</td>
<td>Y</td>
<td>Arthritis</td>
<td>N</td>
<td>Y</td>
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<tr>
<td>Anemia</td>
<td>N</td>
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<td>N</td>
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<td>Arthritis</td>
<td>N</td>
<td>Y</td>
<td>Arthritis</td>
<td>N</td>
<td>Y</td>
</tr>
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<td>N</td>
<td>Y</td>
<td>Anemia</td>
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<td>Y</td>
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**FAMILY HISTORY**

<table>
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<th>N</th>
<th>Condition (N or Y)</th>
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<th>N</th>
</tr>
</thead>
</table>
### Department of Urology

#### MEDICAL & FAMILY HISTORY CONTINUED

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MRN #</th>
<th>Medical &amp; Family History - Page 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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**History and Significance of the Following:**

<table>
<thead>
<tr>
<th>System</th>
<th>Symptom</th>
<th>U</th>
<th>N</th>
<th>Y</th>
<th>Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERAL</strong></td>
<td>Tired easily, weakness</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Weakness</td>
</tr>
<tr>
<td></td>
<td>Marked weight change</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Weight loss</td>
</tr>
<tr>
<td></td>
<td>Night sweats</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Night sweats</td>
</tr>
<tr>
<td></td>
<td>Persistent fever</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Persistent fever</td>
</tr>
<tr>
<td></td>
<td>Sensitivity to heat</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Sensitivity to heat</td>
</tr>
<tr>
<td></td>
<td>Sensitivity to cold</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Sensitivity to cold</td>
</tr>
<tr>
<td><strong>SKIN</strong></td>
<td>Rash (rash)</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Rash</td>
</tr>
<tr>
<td></td>
<td>Change in color</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Change in color</td>
</tr>
<tr>
<td></td>
<td>Change in hair</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Change in hair</td>
</tr>
<tr>
<td></td>
<td>Change in nails</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Change in nails</td>
</tr>
<tr>
<td><strong>EYES</strong></td>
<td>Trouble seeing</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Vision problems</td>
</tr>
<tr>
<td></td>
<td>Eye pain</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Eye pain</td>
</tr>
<tr>
<td></td>
<td>Exudated eyes</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Exudated eyes</td>
</tr>
<tr>
<td></td>
<td>Double vision</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Double vision</td>
</tr>
<tr>
<td></td>
<td>Weak glasses</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Weak glasses</td>
</tr>
<tr>
<td><strong>EARS</strong></td>
<td>Loss of hearing</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Hearing loss</td>
</tr>
<tr>
<td></td>
<td>Ringing in ears</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Ringing in ears</td>
</tr>
<tr>
<td></td>
<td>Discharge</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Discharge</td>
</tr>
<tr>
<td><strong>NOSE</strong></td>
<td>Loss of smell</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Smell loss</td>
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<tr>
<td></td>
<td>Frequent colds</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Frequent colds</td>
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<tr>
<td></td>
<td>Obstruction</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Obstruction</td>
</tr>
<tr>
<td></td>
<td>Excessive discharge</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Excessive discharge</td>
</tr>
<tr>
<td><strong>NORTH</strong></td>
<td>Nasal polyps</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Nasal polyps</td>
</tr>
<tr>
<td></td>
<td>Sore nose</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Sore nose</td>
</tr>
<tr>
<td></td>
<td>Soreness of tongue</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Sore tongue</td>
</tr>
<tr>
<td></td>
<td>Dental problems</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Dental problems</td>
</tr>
<tr>
<td><strong>THROAT</strong></td>
<td>Painful drainage</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Throat pain</td>
</tr>
<tr>
<td></td>
<td>Soreness</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Sore throat</td>
</tr>
<tr>
<td></td>
<td>Allophones</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Allophones</td>
</tr>
<tr>
<td><strong>BREASTS</strong></td>
<td>Lumps</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Lumps</td>
</tr>
<tr>
<td></td>
<td>Discharge</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Discharge</td>
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</tbody>
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**CARDIO-RESPIRATORY SYSTEM**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>U</th>
<th>N</th>
<th>Y</th>
<th>Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough, persisting</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Cough</td>
</tr>
<tr>
<td>Breathless (dyspnea)</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Breathless</td>
</tr>
<tr>
<td>Sleepy spells</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Sleep spells</td>
</tr>
<tr>
<td>Wheezing</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Wheezing</td>
</tr>
<tr>
<td>Chest pain or discomfort</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Chest pain</td>
</tr>
<tr>
<td>Pain on breathing while lying down</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Breathing pain</td>
</tr>
<tr>
<td>Swelling on ankles</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Swelling</td>
</tr>
<tr>
<td>Rheumatic fingers or lips</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Rheumatic fingers</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>Palpitations</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Palpitations</td>
</tr>
</tbody>
</table>

**DIGESTIVE SYSTEM (Typical Eating Habits):**

<table>
<thead>
<tr>
<th>Meal</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
</tr>
<tr>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>Dinner</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptom</th>
<th>U</th>
<th>N</th>
<th>Y</th>
<th>Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in appetite</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Appetite loss</td>
</tr>
<tr>
<td>Difficulty swallowing</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Difficulty swallowing</td>
</tr>
<tr>
<td>Heartburns</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Heartburns</td>
</tr>
<tr>
<td>Abdominal distress</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>Abdominal distress</td>
</tr>
</tbody>
</table>

**GYNO-OB**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Description</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Starting menstruation at age</th>
<th>Date of last PAP test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval between periods</td>
<td>days</td>
</tr>
<tr>
<td>Flow</td>
<td>Light</td>
</tr>
<tr>
<td>Date of last period</td>
<td></td>
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<table>
<thead>
<tr>
<th>Number of pregnancies</th>
<th>Number of miscarriages</th>
<th>Number of births</th>
<th>% of babies at birth</th>
</tr>
</thead>
</table>

| Signature of person completing form | Date |
Dr. Merrill Patient History Form

MORE QUESTIONS

Did you ever smoke? YES NO How old were you when you started smoking? __________

Cigars? Yes NO How old were you when you got to 1 pack a day? __________

Pipe? Yes NO How old were you when you got to 2 packs a day? __________

Chew? Yes NO How old were you when you quit? __________

How often do you have a drink containing alcohol? (e.g. daily, weekly, monthly) __________

How many drinks do you have on a typical day when you do drink alcohol? __________

When did you most recently smoke marijuana? __________

When did you most recently use cocaine or any other drug? __________

When did you most recently inject any nonprescribed drug? __________

What is the highest grade you finished in school? __________

What kinds of work do you do now, and have you done in the past? __________

Have you ever worked with rubbers, dyes or paints? YES NO If, so for how long? __________

Have you ever had a blood transfusion? YES NO If so, when? __________

Have you ever received the drug cyclophosphamide (Cytoxan)? YES NO

What problems do you have with urination? __________

How many times do you get up to urinate in a usual night? __________

Do you see blood in your urine? YES NO

Do you have a history of having multiple urinary tract infections? YES NO

How much weight have you gained or lost in the past month? (+ / -) __________

Do you get a rash or swelling from rubber, for example after blowing up a balloon? YES NO

Have you ever had a seizure? YES NO

Have you ever had a stroke or a near stroke? YES NO

Have you ever had phlebitis or blood clots in your legs, arms or lungs? YES NO

Please circle the ONE following statement that BEST describes you.

I can walk on level ground, non-stop for 20 minutes and cover 1 mile.

I can walk for 20 minutes without stopping provided I walk slowly.

I must stop and rest after 5-10 minutes.

I must stop and rest going from room to room in the house.

I am short of breath just sitting.
THE NEXT TWO PAGES LABELED:

1) AUA SYMPTOM SCORE
2) SEXUAL HEALTH INVENTORY FOR MEN

ARE ONLY TO BE FILLED OUT BY MEN. WOMEN MAY DISREGARD THESE NEXT TWO PAGES.
# AUA SYMPTOM SCORE

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Date</th>
</tr>
</thead>
</table>

Highlight or bold or change font color of the response correct for you and type in your score in the far right box for all SEVEN questions.

1. Incomplete emptying: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Less than 1 time in 5</th>
<th>Less than half the time</th>
<th>About half the time</th>
<th>More than half the time</th>
<th>Almost always</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

2. Frequency: Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Less than 1 time in 5</th>
<th>Less than half the time</th>
<th>About half the time</th>
<th>More than half the time</th>
<th>Almost always</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

3. Intermittency: Over the past month, how often have you found that you stopped and started again several times when you urinated?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Less than 1 time in 5</th>
<th>Less than half the time</th>
<th>About half the time</th>
<th>More than half the time</th>
<th>Almost always</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

4. Urgency: Over the past month, how often have you found it difficult to postpone urination?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Less than 1 time in 5</th>
<th>Less than half the time</th>
<th>About half the time</th>
<th>More than half the time</th>
<th>Almost always</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

5. Weak-stream: Over the past month, how often have you had a weak stream?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Less than 1 time in 5</th>
<th>Less than half the time</th>
<th>About half the time</th>
<th>More than half the time</th>
<th>Almost always</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

6. Straining: Over the past month, how often have you had to push or strain to begin urination?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Less than 1 time in 5</th>
<th>Less than half the time</th>
<th>About half the time</th>
<th>More than half the time</th>
<th>Almost always</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

7. Nocturia: Over the past month or so, how many times did you get up to urinate from the time you went to bed until the time you got up in the morning?

<table>
<thead>
<tr>
<th>None</th>
<th>1 time</th>
<th>2 times</th>
<th>3 times</th>
<th>4 times</th>
<th>5 or more times</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Add up your scores for total AUA score =

Quality of Life Due to Urinary Symptoms: If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? (Bold, Highlight or Underline)

Delighted Pleased Mostly satisfied Mixed Mostly dissatisfied Unhappy Terrible
SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: ___________________________ TODAY'S DATE: __________

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that best describes your own situation. Please be sure that you select one and only one response for each question.

OVER THE PAST 6 MONTHS:

<table>
<thead>
<tr>
<th>1. How do you rate your confidence that you could get and keep an erection?</th>
<th>VERY LOW</th>
<th>LOW</th>
<th>MODERATE</th>
<th>HIGH</th>
<th>VERY HIGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?</th>
<th>NO SEXUAL ACTIVITY</th>
<th>ALMOST NEVER OR NEVER</th>
<th>A FEW TIMES (MUCH LESS THAN HALF THE TIME)</th>
<th>SOMETIMES (ABOUT HALF THE TIME)</th>
<th>MOST TIMES (MUCH MORE THAN, HALF THE TIME)</th>
<th>ALMOST ALWAYS OR ALWAYS</th>
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<tr>
<th>3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?</th>
<th>DID NOT ATTEMPT INTERCOURSE</th>
<th>ALMOST NEVER OR NEVER</th>
<th>A FEW TIMES (MUCH LESS THAN HALF THE TIME)</th>
<th>SOMETIMES (ABOUT HALF THE TIME)</th>
<th>MOST TIMES (MUCH MORE THAN, HALF THE TIME)</th>
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<tr>
<th>4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?</th>
<th>DID NOT ATTEMPT INTERCOURSE</th>
<th>EXTREMELY DIFFICULT</th>
<th>VERY DIFFICULT</th>
<th>DIFFICULT</th>
<th>SLIGHTLY DIFFICULT</th>
<th>NOT DIFFICULT</th>
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<tr>
<th>5. When you attempted sexual intercourse, how often was it satisfactory for you?</th>
<th>DID NOT ATTEMPT INTERCOURSE</th>
<th>ALMOST NEVER OR NEVER</th>
<th>A FEW TIMES (MUCH LESS THAN HALF THE TIME)</th>
<th>SOMETIMES (ABOUT HALF THE TIME)</th>
<th>MOST TIMES (MUCH MORE THAN, HALF THE TIME)</th>
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Add the numbers corresponding to questions 1-5. TOTAL: __________

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED  8-11 Moderate ED  12-16 Mild to Moderate ED  17-21 Mild ED