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Erectile Dysfunction Risk Assessment Form

Title: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other ☐	**D.o.B.:** _ _ / _ _ / _ _	**Age:** _____
Name:	**Home Address:**	
Surname:		
Email:	**Name & Address of GP** (optional)	
Telephone:	**Would you like your GP to be informed of this consultation?** Yes ☐ No ☐	

Please answer the following questions

Have you had a serious reaction to an ED medicine before? Yes ☐ No ☐ *If yes, please describe the product/reaction*	Do you have higher or lower than normal blood pressure? Yes ☐ No ☐ *If yes, please provide details*
Have you been advised to avoid strenuous exercise? Yes ☐ No ☐ *If yes, please provide the reason*	Do you have a medical history of the following: heart disease, heart failure, heart attack, arrhythmias (heart rhythm problems), angina (chest pain during exertion), stroke, mini stroke (transient ischaemic attack), sight loss due to poor circulation, inherited eye disease – retinitis pigmentosa, severe kidney or liver disease, deformity of the penis (e.g. Peryonie's Disease), painful erections, sickle cell disease / leukaemia / multiple myeloma, bleeding conditions (e.g. haemophilia), stomach ulcers (e.g. gastric/peptic ulcer)? Yes ☐ No ☐
Is walking or running difficult for you? Yes ☐ No ☐	Do you have symptoms of depression and have not seen a GP? Yes ☐ No ☐ *If yes, please provide details*
Do you have difficulty in getting or maintaining an erection? Yes ☐ No ☐	Do you have any recent or past medical history of note? Yes ☐ No ☐ *If yes, please provide details*
Are you aware that erectile dysfunction can sometimes mask underlying medical conditions, so it is recommended that you agree to consult your doctor about this? Yes ☐ No ☐	Do you take any current or repeat medicines? Yes ☐ No ☐ *If yes, please list them in the box below*

Please list all your current prescription medication including any medication you buy over the counter

Please write below any further information which may be relevant e.g. conditions…

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FOR OFFICIAL USE

SHIM

Erectile Dysfunction severity indicator test

Over the past 6 months:						
How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No sexual activity	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost most always or always
	0	1	2	3	4	5
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did not attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than, half the time	Almost always or always
	0	1	2	3	4	5
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did not attempt intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
	0	1	2	3	4	5
When you attempted sexual intercourse, how often was it satisfactory for you?	Did not attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than, half the time)	Almost always or always
	0	1	2	3	4	5

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 **Excluded**
- 8-11 - Moderate ED **Included**
- 12-16 - Mild to Moderate ED **Included**
- 17-21 - Mild ED **Excluded**

Initial Consultation

Date	Medicine	Qty	Details	Price	Comment

Additional erectile dysfunction advice					
Smoking ☐	Alcohol ☐	Depression ☐	ED medicines side effects ☐	Patient information leaflet given ☐	Lifestyle advice ☐

Healthcare professional declarations	
I confirm that the patient is not contraindicated based on the information provided by the PGD	☐
I have explained the potential warnings and side effects of the treatment to the patient, and requested they report them if they occur	☐
I have provided the patient with an information leaflet (PIL) for the treatment I am administering, and advised them to read it	☐

Healthcare Professional Name	**Signature**	**Date**

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PATIENT CONSENT

I have received information on the risks and benefits of the erectile dysfunction medicines recommended and fully understand them. I have also had the opportunity to ask questions. I consent to the erectile dysfunction medicines being given at each appointment.

Patient signature _____ **Date** _____

Record of Treatment Provision

New risk assessment form required after 10 consultations.

For each follow-up consultation

Appointment	ED medicine	Qty	Details	Change in medical history?	Healthcare professional Signature	Price
No.1.				Yes ☐ No ☐		
Patient Signature				Date		
No.2.				Yes ☐ No ☐		
Patient Signature				Date		
No.3.				Yes ☐ No ☐		
Patient Signature				Date		
No.4.				Yes ☐ No ☐		
Patient Signature				Date		
No.5.				Yes ☐ No ☐		
Patient Signature				Date		
No.6.				Yes ☐ No ☐		
Patient Signature				Date		
No.7.				Yes ☐ No ☐		
Patient Signature				Date		
No.8.				Yes ☐ No ☐		
Patient Signature				Date		
No.9.				Yes ☐ No ☐		
Patient Signature				Date		
No.10.				Yes ☐ No ☐		
Patient Signature				Date		