

Decreased Sexual Desire Screener (DSDS)

1. In the past, was your level of sexual desire/interest good and satisfying to you?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
2. Has there been a decrease in your level of sexual desire/interest?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
3. Are you bothered by your decreased level of sexual desire/interest?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
4. Would you like your level of sexual desire/interest to increase?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
5. Please check all the factors that you feel may be contributing to your current decrease in sexual desire/interest:		
A. An operation, depression, injuries, or other medical condition	No <input type="checkbox"/>	Yes <input type="checkbox"/>
B. Medications, drugs or alcohol you are currently taking	No <input type="checkbox"/>	Yes <input type="checkbox"/>
C. Pregnancy, recent childbirth, menopausal symptoms	No <input type="checkbox"/>	Yes <input type="checkbox"/>
D. Other sexual issues you may have (pain, decreased arousal, orgasm)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
E. Your partner's sexual problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
F. Dissatisfaction with your relationship or partner	No <input type="checkbox"/>	Yes <input type="checkbox"/>
G. Stress or fatigue	No <input type="checkbox"/>	Yes <input type="checkbox"/>

Results analysis:

NO to Q1, 2, 3 or 4 =
Not generalized
acquired HSDD

**YES to all Q1–4 &
NO to all parts of Q5,**
clinician to use best
judgement to confirm a
diagnosis of generalized
acquired HSDD

**YES to all Q1–4 &
YES to any Q5 factor,**
clinician to use best
judgement to determine
diagnosis