J. Kyle Mathews, MD
Plano Urogynecology Associates / Plano OBGyn Associates

Welcome to The Center for Pelvic Reconstructive Surgery, Medicine, & Continence

When you come to see a new doctor, you may have questions about what to expect at your first visit. We hope this letter will prepare you. My specialty is exclusively devoted to the treatment of women with pelvic floor disorders. You can read more about Dr. Mathews and the Center at the website at www.drjkm.com. There you will find helpful informantion about your condition.

When checking in, our service representative will request the following information:

- Insurance card and co-payment, if applicable
- Physician referral, if required by insurance provider
- Name and address of referring physician (**This is very important** !)
- Completed health history form (enclosed)
- Copies of other medical records, if appropriate
- Current medication bottle(s)

We have enclosed a comprehensive health history questionnaire for you to complete prior to coming in for your visit. This f important information about your medical history, which will enable us to provide you with the best care possible. The questionnaire will require about 40 minutes of your time to complete.

JKM

We now use an electronic medical record to document your care. This allows our team to enter information directly into your record while you are here. Your referring physician will be sent a letter documenting your care after your visit, usually the same day. For this reason, it is important that you provide us with the name and address of your referring physician.

When your visit is complete, you will return to the reception desk. Our service representatives will give you printed information about your visit and answer questions about scheduling future tests or treatments.

Our team is devoted to providing you with the highest quality of female pelvic medical and surgical care. Let us know if we do not meet your expectations so we can address them promptly. If you think we can improve our care in any way, feel free to make suggestions. Our patients suggested much of what we do today.

Sincerely,
J. Kyle Mathews. MD

Plano Urogynecology Associates / Plano OB/Gyn Associates

JKM

J. Kyle Mathews, MD Plano Urogynecology Associates / Plano OBGyn Associates

A. Patient History

1. Appointment Date: / /
2. ID:
3. Patient name: Last _____ First _____
4. Birth Date: / /
5. Occupation: _____
6. Age: _____
7. Current city/town: _____ 8. Current Zip Code: _____
9. Primary language: _____

10. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living with partner
11. School completed: ☐ High School ☐ College ☐ Graduate degree ☐ Other:
12. Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ North Asian ☐ South Asian ☐ Pacific Islander ☐ Native American ☐ Other: _____

Main support person(spouse, partner, etc)
Relationship of main support person: _____
Occupation of main support person: _____
Telephone number of main support person: _____

Referring Physician: Primary Physician:
Address: _____
Phone #: _____

B. History of Present Illness

Please describe the nature of the problem that brought you to our clinic:

Have you seen any other physicians for this problem? If yes, please list the physician and any evaluation or therapy.

When did this problem start?
What have you tried for relief?
What makes the problem better?
Does anything worsen the problem?
How severe is the problem now?

C. Urogyn

Genitourinary

1. In a typical day, how many times do you urinate?: (***frequency***) _____

2. In a typical night, how many times do you awaken to urinate?: (***nocturia***) _____

3. Do you leak urine when you do not want to (***SUI***)?: □ No □ Yes *If yes, check any conditions that cause you to leak:*

   3a. □ Coughing □ Sneezing □ Laughing □ Exercise □ Upon standing

   □ Housework □ Lifting □ Intercourse

4. In a typical day, do you experience frequent, strong urges to urinate?: (***urgency***) □ No □Yes

   4a. *If yes, do you leak urine during these strong urges: (**urge incontinence**)* □ No □Yes

5. In a typical week, do you have **difficulty emptying your bladder**?: □ No □Yes

6. Do you wear **pads**: □ No □Yes:

   6a. *If yes, how many pads do you wear per day?* _____

7. How much fluids do you drink in a typical day? (***fluid intake***) _____

8. Please list any **overactive bladder medicines** you have tried and duration of use? _____

_____

Gastrointestinal

9. In a typical week, how many **bowel movements** do you have?: _____

10. In a typical week, how many **laxatives** do you use?: _____

11. In a typical week, do you have **difficulty having bowel movements**?: □ No □Yes

12. In a typical week, do you leak stool when you do not want to?: (***fecal incontinence***) □ No □Yes

13. In a typical week, do you leak gas when you do not want to?: (***flatal incontinence***) □ No □Yes

Gynecologic

14. Do you feel that your bladder, uterus, vagina or rectum are falling out?: (***prolapse symptoms***) □ No □Yes

15. Are you currently **sexually active**?: □ No □Yes

   15a. Do you have any **physical problems** with sexual relations?: □ No □Yes

   15b. Do you have pain with sexual intercourse?: (***dyspareunia***) □ No □Yes

D. Cancer Screening

Date of last pap smear:_____/_____ Was it: normal / abnormal

History of abnormal pap smears?: yes / no If yes, please explain: _____

Date of last mammogram:_____/_____ Was it: normal / abnormal

History of abnormal mammograms?: yes / no If yes, please explain: _____

Date of last colonoscopy:_____/_____ Was it: normal / abnormal

If abnormal, please explain: _____

Have you received a Cervical Cancer Vaccination? Yes / No : If yes, please give the date: _____

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3108 Midway Road Suite 210 Plano, TX 75093

E. Allergies

(Please list any drug allergies)

Medication	Reaction	Medication	Reaction

F. Medications

(Please list any over the counter medications in addition to prescribed medicines)

Medication name	Dose	Frequency	Prescribing Physician

G. Past Medical History

(Please check any medical problems you were diagnosed with as an adult)

☐ Heart disease	☐ Heart attack	☐ Asthma	☐ Uterine cancer
☐ High Blood Pressure	☐ Stroke	☐ Heart murmur	☐ Ovarian cancer
☐ Diabetes	☐ Blood clots (DVT, etc.)	☐ Thyroid disease	☐ Pelvic radiation for cancer
☐ COPD	☐ Pulmonary embolism	☐ Lupus	☐ Bladder cancer

☐ Cancer:_____

☐ Serious injuries (Please explain):_____

☐ Procedures to your cervix (Conization, LEEP, etc.). Please list procedure, reason for procedure and date of procedure:_____

_____

_____

Other Medical Diagnoses (please list)	Date of Diagnosis	Treating Physician

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H. Past Surgical History

(Please list any previous surgeries/operations)

☐ Hysterectomy Date of operation:_____

Please check the type of hysterectomy

☐ Abdominal hysterectomy ☐ Vaginal hysterectomy ☐ Supracervical hysterectomy ☐ Laparoscopic

☐ Both ovaries were removed ☐ Right ovary was removed ☐ Left ovary was removed

Reason for surgery:_____

Any other procedures performed during surgery:_____

☐ Removal of ovaries as a separate surgery Date of operation:_____

Please check the type of surgery

☐ Laparoscopy ☐ Abdominal incision

☐ Both ovaries were removed ☐ Right ovary was removed ☐ Left ovary was removed

Reason for surgery:_____

Any other procedures performed during surgery:_____

☐ Other Gynecologic surgeries

☐ Tubal ligation Reason and date of surgery:_____

☐ Laparoscopy Reason and date of surgery:_____

_____

_____

☐ Exploratory laparotomy Reason and date of surgery:_____

_____

☐ Other Abdominal surgeries

☐ Appendectomy Reason and date of surgery:_____

☐ Gallbladder removal Reason and date of surgery:_____

☐ Bowel surgery Reason and date of surgery:_____

☐ Vaginal suspension Reason and date of surgery:_____

☐ Cystocele repair Reason and date of surgery:_____

☐ Rectocele repair Reason and date of surgery:_____

☐ Bladder tack Reason and date of surgery:_____

☐ Incontinence surgery

☐ Sling Reason and date of surgery:_____

☐ Burch Reason and date of surgery:_____

☐ MMK Reason and date of surgery:_____

☐ Collagen Reason and date of surgery:_____

Other Surgeries or Hospitalizations (Please list)	Date	Hospital

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I. Obstetrical History

Please list number of:
Pregnancies(All pregnancies)_____ Miscarriages_____ Abortions_____ Living Children_____

No	Birth Date	Birth Weight	Male/Female	Weeks/Months of pregnancy	Type of Delivery	Tears into Rectum Y/N
1	__/__/__	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	------- Y / N ---------
2	__/__/__	_____	M / F	_____weeks / months	Vaginal / C/section / Vacuum / Forceps	------- Y / N ---------
3	__/__/__	_____	M / F	_____weeks / months	Vaginal / C/section / Vacuum / Forceps	------- Y / N ---------
4	__/__/__	_____	M / F	_____weeks / months	Vaginal / C/section / Vacuum / Forceps	------- Y / N ---------
5	__/__/__	_____	M / F	_____weeks / months	Vaginal / C/section / Vacuum / Forceps	------- Y / N ---------
6	__/__/__	_____	M / F	_____weeks / months	Vaginal / C/section / Vacuum / Forceps	------- Y / N ----------
7	__/__/__	_____	M / F	_____weeks / months	Vaginal / C/section / Vacuum / Forceps	------- Y / N ----------
8	__/__/__	_____	M / F	_____weeks / months	Vaginal / C/section / Vacuum / Forceps	------- Y / N ---------

J. Gynecologic History

Menstrual History
How old were you when you had your first period? _____

First day of last menstrual cycle:_____/_____/_____ Age of menopause(if applicable):_____

How often do you have a menstrual cycle:_____ Length of bleeding:_____
If abnormal cycles, please explain:_____

If you are sexually active, what birth control (if any) do you use?: _____ ☐ None

History of sexually transmitted diseases?: yes / no If yes, please explain:_____

K. Social History

	No	Yes	
1. Do you smoke currently?			If yes: _____ # packs per day for _____ years
2. Did you smoke in the past?			If yes, when did you quit?_____
3. Do you drink alcohol?			If yes, how much:_____
4. Do you use any street drugs			If yes, please explain:_____
5. Do you exercise regularly			If yes, please describe:_____
6. Do you drink caffeine			If yes, please describe:_____

L Family History.

Has anyone in your family had any of these diseases? If so, please give relationship to you.

1. Breast cancer:_____ 2. Heart disease:_____
3. Ovarian cancer:_____ 4. Colon cancer:_____
5. Prolapse (including cystocele or rectocele):_____
6. Urinary Incontinence:_____
7. Other disease(s), please list:_____

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M. Review of Systems

(In the past 7 days, have you been bothered by any of the symptoms below?)

Constitutional:	☐ Fever ☐ Loss of appetite	☐ Fatigue	☐ Weight change
Eyes:	☐ Eye pain	☐ Blurry vision	☐ Loss of vision
ENMT:	☐ Swollen neck glands	☐ Loss of hearing	
Cardiovascular:	☐ Chest pain ☐ Fainting (syncope)	☐ Heart palpitations ☐ Heart murmur	☐ Leg swelling
Respiratory:	☐ Shortness of breath	☐ Wheezing	☐ Frequent coughing
Gastrointestinal:	☐ Abdominal pain ☐ Blood in stool ☐ Decreased appetite	☐ Constipation ☐ Vomiting	☐ Diarrhea ☐ Nausea
Genitourinary:	☐ Abnormally heavy bleeding ☐ Painful intercourse ☐ Urinary urgency ☐ Painful urination		☐ Irregular menstrual cycles ☐ Abnormal discharge ☐ Urinary frequency ☐ Blood in urine
Musculoskeletal:	☐ Joint pain ☐ Difficulty walking	☐ Joint stiffness ☐ Muscle pain	☐ Back pain ☐ Muscle weakness
Neurological:	☐ Frequent headaches	☐ Frequent dizziness	☐ Seizures
Skin:	☐ Rash	☐ Itching	
Breast:	☐ Breast mass	☐ Breast pain	☐ Nipple discharge
Psychiatric:	☐ Depression	☐ Anxiety	☐ Memory loss or confusion
Endocrine:	☐ Diabetes	☐ Hyperthyroidism	☐ Hypothyroidism

Patient signature Date

Physician signature(Above information was reviewed) Date

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Plano Urogynecology and Reconstructive Surgery

Urinary Questionnaire I (MESA)

Instructions:

These questions ask about symptoms you may have related to urine leakage. Please indicate the response that best represents how frequently you experience each symptom by placing an "X" under the appropriate response..

Part I: (Stress Symptoms)

	Never	Rarely	Sometimes	Often
Does coughing gently cause you to lose urine?				
Does coughing hard cause you to lose urine?				
Does sneezing cause you to lose urine?				
Does lifting things cause you to lose urine?				
Does bending cause you to lose urine?				
Does laughing cause you to lose urine?				
Does walking briskly or jogging cause you to lose urine?				
Does straining, if you are constipated, cause you to lose urine?				
Does getting up from a sitting to a standing position cause you to lose urine?				

During the last **7 days**, how many times did you accidentally leak urine when you were performing some physical activity such as coughing, sneezing, lifting or exercise? # of times _____

Urinary Questionnaire I (MESA)

Instructions:

These questions ask about symptoms you may have related to urine leakage. Please indicate the response that best represents how frequently you experience each symptom by placing an "X" under the appropriate response..

Part II: (Urge Symptoms)

	Never	Rarely	Sometimes	Often
Some women receive very little warning and suddenly find that they are losing, or are about to lose, urine beyond their control. How often does this happen to you?				
	Never	Rarely	Sometimes	Often
If you can't find a toilet or find that the toilet is occupied, and you have an urge to urinate, how often do you end up losing urine or wetting yourself?				
	Never	Rarely	Sometimes	Often
Do you lose urine when you suddenly have he feeling that your bladder is very full?				
	Never	Rarely	Sometimes	Often
Does washing your hands cause you to lose urine?				
	Never	Rarely	Sometimes	Often
Does cold weather cause you to lose urine?				
	Never	Rarely	Sometimes	Often
Does drinking cold beverages cause you to lose urine?				
	Never	Rarely	Sometimes	Often
During the last 7 days, how many times did you accidentally leak urine when you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?				

# of times in the past 7 days? _____

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Pelvic Floor Questionnaire (PFDI)

Instructions:

Please answer the following questions by placing an "X" in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms over the **last three months**. Thank you for your help.

Date: _____ / _____ / _____

		No	Yes		Not at all	Somewhat	Moderately	Quite a bit
1	Do you usually experience *pressure* in the lower abdomen?	0		If yes, how much does this bother you?	1	2	3	4
2	Do you usually experience *heaviness or dullness* in the pelvic area?	0		If yes, how much does this bother you?	1	2	3	4
3	Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	0		If yes, how much does this bother you?	1	2	3	4
4	Do you usually have to push on the vagina or around the rectum to have or complete bowel movement?	0		If yes, how much does this bother you?	1	2	3	4
5	Do you usually experience a feeling of incomplete bladder emptying?	0		If yes, how much does this bother you?	1	2	3	4
6	Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0		If yes, how much does this bother you?	1	2	3	4
7	Do you feel you need to strain too hard to have a bowel movement?	0		If other than never, how much does this bother you?	1	2	3	4
8	Do you feel you have not completely emptied your bowels at the end of a bowel movement?	0		If other than never, how much does this bother you?	1	2	3	4
9	Do you usually lose stool beyond your control if your stool is well formed?	0		If yes, how much does this bother you?	1	2	3	4
10	Do you usually lose stool beyond your control if your stool is loose or liquid?	0		If yes, how much does this bother you?	1	2	3	4

		No	Yes		Not at all	Somewhat	Moderately	Quite a bit
11	Do you usually lose gas from the rectum beyond your control?	0		If yes, how much does this bother you?	1	2	3	4
12	Do you usually have pain when you pass your stool?	0		If yes, how much does this bother you?	1	2	3	4
13	Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0		If other than never, how much does this bother you?	1	2	3	4
14	Does a part of your bowel every pass through the rectum and bulge outside during or after a bowel movement?	0		If yes, how much does this bother you?	1	2	3	4
15	Do you usually experience frequent urination?	0		If yes, how much does this bother you?	1	2	3	4
16	Do you usually experience urine leakage associated with a feeling of urgency that is a strong sensation of needing to go to the bathroom?	0		If yes, how much does this bother you?	1	2	3	4
17	Do you usually experience urine leakage related to coughing, sneezing, or laughing?	0		If yes, how much does this bother you?	1	2	3	4
18	Do you usually experience small amounts of urine leakage (that is, drops)?	0		If yes, how much does this bother you?	1	2	3	4
19	Do you usually experience difficulty emptying your bladder?	0		If yes, how much does this bother you?	1	2	3	4
20	Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0		If yes, how much does this bother you?	1	2	3	4

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Plano Urogynecology and Reconstructive Surgery

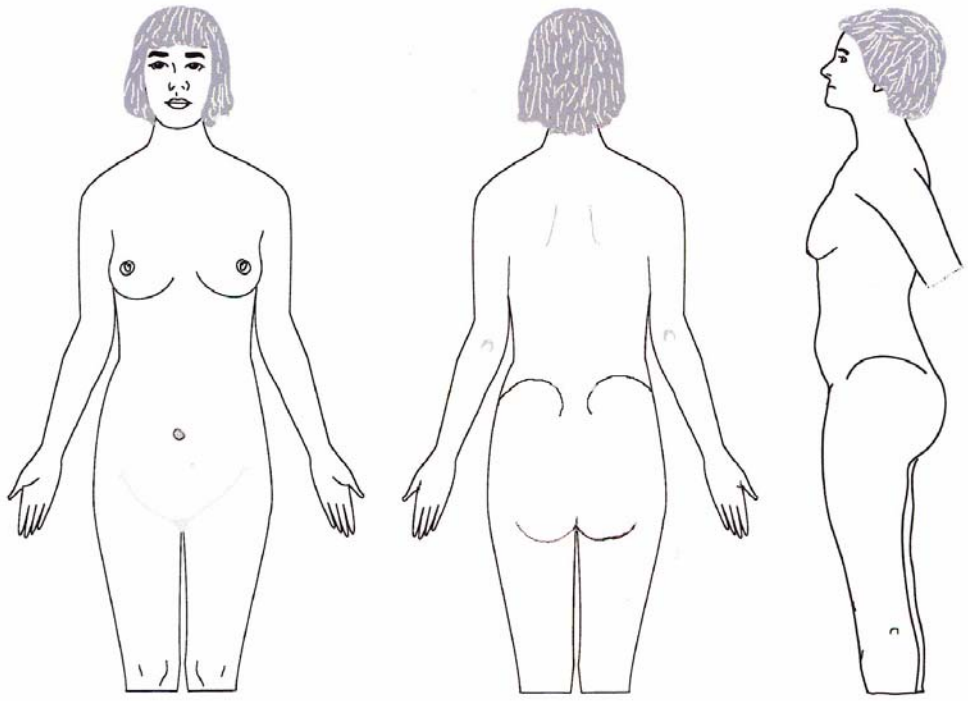
Pain worksheet: ***Instructions:***

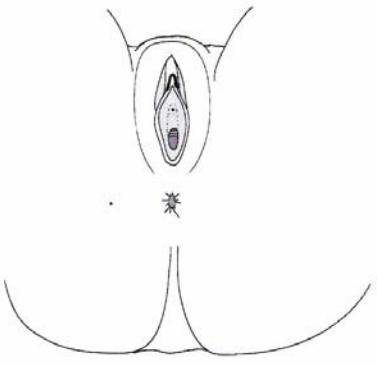
Please indicate the location(s) on the body maps below by marking, or circling the appropriate spot(s) in response to the following questions:

Are you in any pain or discomfort right now?

Pain level (please circle) 0 - no pain 1 2 3 4 5 6 7 8 9 10 – worst pain of my life
Please mark the location of pain below with an "X"

Discomfort level 0 - no discomfort 1 2 3 4 5 6 7 8 9 10 – worst discomfort of my life
Please mark the location of discomfort below with a "O"





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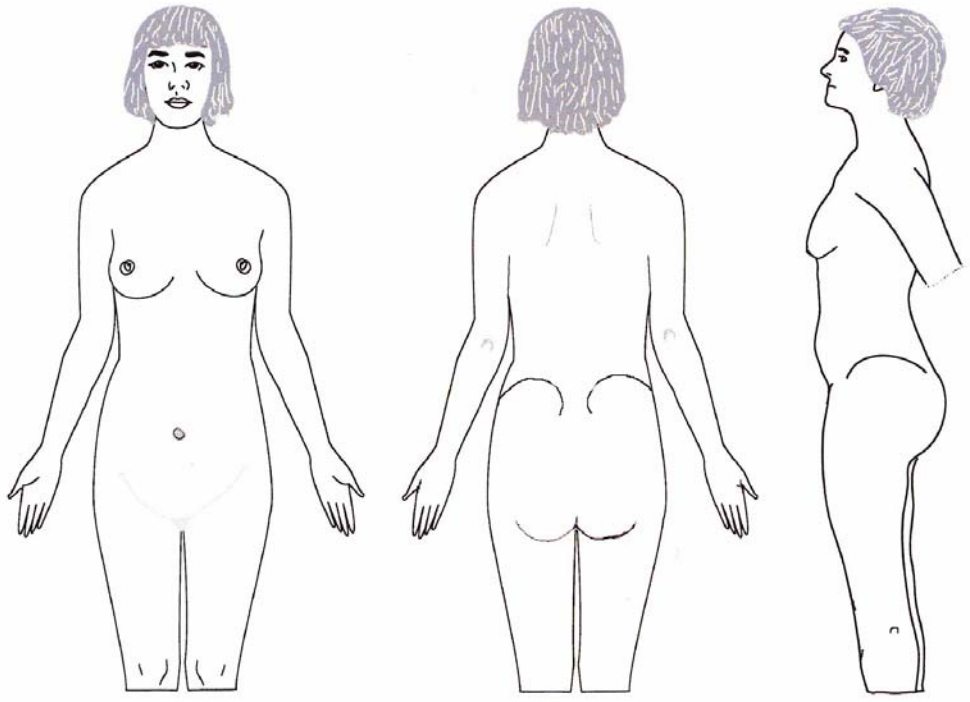
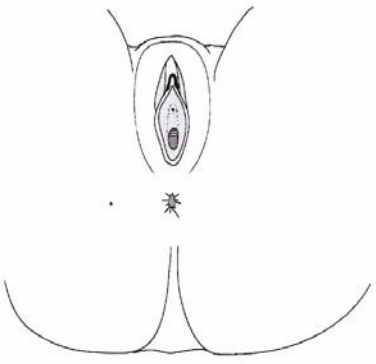
Bladder sensation worksheet: Instructions:

Please indicate the location(s) on the body maps below by placing and "X" or circling the appropriate spot(s) in response to the following question:

When you feel an urge to empty your bladder, where in your body is that urge located?





The Pelvic Pain and Urinary/Frequency (PUF) Patient Symptom Scale

Please circle the answer that best describes how you feel for each question.

	0	1	2	3	4	Symptom Score	Bother Score
1. How many times do you go to the bathroom during the day?	3–6	7–10	11–14	15–19	20+		
2a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
2b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3. Are you currently sexually active? Yes ___ No ___							
4a. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
4b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
6. Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7a. If you have pain, is it usually...		Mild	Moderate	Severe			
7b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8a. If you have urgency, is it usually...		Mild	Moderate	Severe			
8b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
					Symptom Score (1, 2a, 4a, 5, 6, 7a, 8a) =		
					Bother Score (2b, 4b, 7b, 8b) =		
					Total Score (Symptom Score + Bother Score) =		

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Plano Urogynecology and Reconstructive Surgery

Pelvic Floor Questionnaire (PFIQ-7)

Instructions:

Some women find tht bladder, bowel or vaginal symptoms affect their activities, relationships and feelings. For each question, plan an **"X"** in the response that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions ***over the last 3 months***.

How do symptoms or conditions related to the following usually affect your?

1. Ability to do household chores (cooking, housecleaning, laundry)?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine	Not at all	Somewhat	Moderately	Quite a bit
Bowel or rectum	Not at all	Somewhat	Moderately	Quite a bit
Vagina or pelvis				

2. Ability to do physical activities such as walking, swimming or other exercise?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine	Not at all	Somewhat	Moderately	Quite a bit
Bowel or rectum	Not at all	Somewhat	Moderately	Quite a bit
Vagina or pelvis				

3. Entertainment activities such as going to a movie or concert?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine	Not at all	Somewhat	Moderately	Quite a bit
Bowel or rectum	Not at all	Somewhat	Moderately	Quite a bit
Vagina or pelvis				

4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine	Not at all	Somewhat	Moderately	Quite a bit
Bowel or rectum	Not at all	Somewhat	Moderately	Quite a bit
Vagina or pelvis				

5. Participating in social activities outside your home?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine	Not at all	Somewhat	Moderately	Quite a bit
Bowel or rectum	Not at all	Somewhat	Moderately	Quite a bit
Vagina or pelvis				

6. Emotional health (nervouseness, depression, etc.)?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine	Not at all	Somewhat	Moderately	Quite a bit
Bowel or rectum	Not at all	Somewhat	Moderately	Quite a bit
Vagina or pelvis				

7. Feeling frustrated?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine	Not at all	Somewhat	Moderately	Quite a bit
Bowel or rectum	Not at all	Somewhat	Moderately	Quite a bit
Vagina or pelvis				

For Clinic Use

	Mean Bladder/Urine (UIQ-7) (0,1,2,3)
	Mean Colorectal-Anal (CRAIQ-7)
	Mean Vagina/Pelvis (POPIQ-7)
	Scale Bladder/Urine (UIQ-7 *33.33))
	Scale Colorectal-Anal (CRAIQ-7 * 33.33)
	Scale Vagina/Pelvis (POPIQ-7* 33.33)
	PFIQ-7 Summary (=UIQ+CRAIQ+POPIQ)

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Plano Urogynecology and Reconstructive Surgery

Pelvic Floor Questionnaire (PFIQ-7)

Instructions:

Some women find tht bladder, bowel or vaginal symptoms affect their activities, relationships and feelings. For each question, plan an **"X"** in the response that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions ***over the last 3 months***.

How do symptoms or conditions related to the following usually affect your?

1. Ability to do household chores (cooking, housecleaning, laundry)?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

2. Ability to do physical activities such as walking, swimming or other exercise?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

3. Entertainment activities such as going to a movie or concert?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

5. Participating in social activities outside your home?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

6. Emotional health (nervouseness, depression, etc.)?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

7. Feeling frustrated?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

For Clinic Use

	Mean Bladder/Urine (UIQ-7) (0,1,2,3)
	Mean Colorectal-Anal (CRAIQ-7)
	Mean Vagina/Pelvis (POPIQ-7)
	Scale Bladder/Urine (UIQ-7 *33.33))
	Scale Colorectal-Anal (CRAIQ-7 * 33.33)
	Scale Vagina/Pelvis (POPIQ-7* 33.33)
	PFIQ-7 Summary (=UIQ+CRAIQ+POPIQ)

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8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling our?)?

Always (0)	Usually	Sometimes	Seldom	Never (4)

9. When you have sex with your partner, do you have negative emotional reactions such as fear, d'sgust, shame or guilt?

Always (0)	Usually	Sometimes	Seldom	Never(4)

10. Does *yo*ur partner have a problem with erections that affects your sexual activity?

Always(0)	Usually	Sometimes	Seldom	Never(4)

11. Does your partner have a problem with premature ejaculation that affects your sexual activity?

Always(0)	Usually	Sometimes	Seldom	Never(4)

12. Compared to orgasms *you* have had in the past, how intense are the orgasms you have had in the past six months?

Much less intense (0)	Less intense	Same intensity	More intense	Much more intense (4)

For Clinic Use Only

Scoring

Scores are calculated by totaling the scores for each question with 0-never, 4=always. Reverse scoring is used for items 1,2,3 and 4. The short form questionna're can be used with up to two missing responses. To handle missing values the sum is calculated by multiplying the number of items by the mean of the answered items. If there are more than two missing responses, the short form no longer accurately predicts long form scores. Short form scores can only be reported as total or on an item basis. Although the short form reflects the content of the three factors in the long form, it is not possible to analyze data at the factor level. To compare long and short form scores multiply the short form score by 2.58

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