



ADVANCED PAIN CENTERS

ED QUESTIONNAIRE

Please answer the following questions:

1. The name and telephone number of your primary care physician and/or any specialists that you have seen relative to this condition.

2. How often and what symptoms do you exhibit with your condition (ie, lack of erection regularly, inability to keep an erection, anxiety during sexual intercourse, nocturnal erections, etc.)?

3. Have you ever had an adverse reaction to any medication? If yes, please specify.

4. Please list all known allergies:

5. Please list all medications that you are currently taking and the dosage:

10. What is your goal in entering this study. Please be specific:

Signature: _____ Date: _____

Printed Name: _____