Erectile Dysfunction **Date: _ _ / _ _ / 2 0 _ _**

Patient's personal details	
Title: Mr: □ Miss: □ Ms: □ Mrs: □ Dr: □	Patient Address:
First Name:	NHS No. (if known):
Last Name:	GP Name and Address:
Telephone:	GP Telephone (if known):
Gender: **Male**. D.O.B: ___ ___/ ___ ___ / ___ ___ ___ ___ Age:	Would you like us to send a copy of this consultation to your GP? □

Patient's personal details			
Tick which of the following applies to you…	***Yes***	***No***	***Add extra details if required.***
Do you have any recent or past medical history of note?	☐	☐	
Do you take any current or repeat medicines?	☐	☐	
Do you have higher or lower than normal blood pressure?	☐	☐	
Have you had a serious reaction to an ED medicine before?	☐	☐	
Do you have a medical history of the following: heart disease, heart attack, 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)?	☐	☐	
Current Health			
Tick which of the following applies to you…	***Yes***	***No***	***Add extra details if required.***
Have you been advised to avoid strenuous exercise?	☐	☐	
Is walking or running difficult for you?	☐	☐	
Do you have symptoms of depression and have not seen a GP?	☐	☐	
What symptoms are you experiencing?			
Tick which of the following applies to you…	***Yes***	***No***	***Add extra details if required.***
Do you have difficulty in getting or maintaining an erection?	☐	☐	
GP appointment...			
Tick which of the following applies to you…	***Yes***	***No***	***Add extra details if required.***
Erectile dysfunction can sometimes mask underlying medical conditions; it is recommended that you agree to consult your doctor about this...	☐	☐	

Write below any further information which may be relevant e.g. medicines taking, conditions suffered, concerns...

For Offical 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 that 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**

Date	**Medicine**	**Quantity**	**Details**	**Price**

Additional erectile dysfunction advice					
Smoking	☐	Alcohol	☐	Depression	☐
Medicine Side Effects	☐	Patient information leaflet given?	☐	Lifestyle advice	☐

PATIENT CONSENT

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

Patient Name / signature ...../ ...../ ..... **Date**.....

Do you consent for our pharmacy and/or our authorising medical agency to contact you regarding customer satisfaction? Yes / No

PHARMACIST AGREEMENT

I have consulted the specific PGD which enables me to supply the listed medicine and have found that the patient is included in treatment and there are no valid exclusions applicable. I have given the patient information on the risks and benefits of the medicines recommended and have done my utmost to ensure the patient fully understands them. I have also given the patient the opportunity to ask questions. This will be carried out at each appointment.

Pharmacist Name / signature ...../ ...../ ..... **Date**.....

Record of Treatment Provision

New risk assessment form required after 14 consultations

For each follow-up consultation

Medicine Supplied	Quantity	Details	Change in medical history	Pharmacist 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		
No.11			Yes ☐ No ☐		
Patient Signature			Date		
No.12			Yes ☐ No ☐		
Patient Signature			Date		
No.13			Yes ☐ No ☐		
Patient Signature			Date		
No.14			Yes ☐ No ☐		
Patient Signature			Date		