MD WELLNESS CENTER AND MED SPA

Dr. Srinivasu Kesa, MD
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6822 E 82ND ST. SUITE #300 INDIANAPOLIS IN 46250 317.548.4666 317.650.2501 317.350.0059

Sexual Wellness Questionnaire For Men

Name: _____

DOB: _____ Ph. No: _____

Email: _____

Mailing Address: _____

What is your main concern? Please write in your own words.		
Do you have any of the following symptoms?	☐ Lack of desire? ☐ Lack of sexual excitement? ☐ Inability to get an erection? ☐ Premature ejaculation? ☐ Delayed ejaculation? ☐ Aversion to sex?	**Please Explain:**
Inability to get an erection:	☐ How long have you had these symptoms? ☐ Are these symptoms situational ex only with specific partners? ☐ Did you have any surgeries on the penis or in the pelvic area in the past? ☐ How confident are you about the ability to get and keep an erection? ☐ When you get an erection, how often were your erections hard enough for penetration? ☐ After penetration, how often were you able to maintain an erection? ☐ Do you have a desire for sex? ☐ Do you get erections with stimulation? ☐ Do you get spontaneous erections at night? ☐ Do you get ejaculation during a sexual encounter?	

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	☐ Do you have any structural abnormalities with the penis? ☐ Previous cancer or cancer treatments?	
Do you ejaculate too early?	☐ Is there anxiety about sex? ☐ Did you have sex too early in life? ☐ Is there a lot of stress going on?	
Do you ejaculate too late, or it takes too long to ejaculate?	☐ How long has this been going on? ☐ Is this repetitive or occasional? ☐ Is it delayed or retrograde? Check urine after ejaculation to see if urine is cloudy. ☐ Any perineal surgeries?	
Is there any depression or anxiety recently?		
Do you use any recreational drugs?		
Do you have any chronic pain related issues?		
How is your relation with your partner?		
Is there any significant life stress happening now?		
Do you take any OTC medications?		
Any previous surgeries ex- Bilateral sympathectomy at L2 or High Bilateral Lymphadenopathy		
Any seizures?		
Any childhood trauma, guilt, or hostility to women?		
Multiple sclerosis or similar neurological conditions?		
Medications	☐ SSRIs- Zoloft, Prozac, Elavil, etc.	

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	☐ Anti-psychotics – ex- Haloperidol or respirodol ☐ Anti HTN meds – B blockers – metoprolol, atenolol, etc ☐ Anti-ulcer meds -- PPI, cimetidine, omeprazole, etc ☐ Cholesterol meds- statins, fibrates ☐ Cholesterol meds- statins, fibrates ☐ Long term usage of anabolic steroids ☐ Nitrates- ex nitrate patch ☐ Blood thinners ☐ Recreational • ☐ Alcohol • ☐ Ecstasy • ☐ Amphetamines • ☐ Cocaine • ☐ Opioids • ☐ Marijuana	
Have you tried any treatments for these symptoms in the past?		
Do you have any prostate problems?		
Heart disease, DM, or stroke		
Have you had any cancer?		
Did you get any radiation treatment for cancer?		
Do you have any hearing problems?		
Do you have any vision problems?		
Any problem with color vision?		
Have you had surgery on your pelvic area?		

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Sexual Wellness Treatment Consent Form

I _____ authorize Midwest Wellness LLC and Dr. Kesa and whomever they designate as their assistants, to help me with my sexual wellness. I understand that my program may consist of hormone replacement, injections, Topicals, nasal sprays, troches, and behavior modifications. It also involves regular blood tests, having Up-to-date Mammograms, and PAP smears.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with these treatments. Risks of this program may include but are not limited to the side effects of hormone replacements and medication reactions. Also, treatment does not guarantee that all patients will see the results. And as we use natural products, results will be slow and gradual.

I understand that the program's success will depend on my efforts and that there are no guarantees or assurances that the program will be successful.

I have read and fully understand this consent form, and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given the time I need to read and understand this form.

[i]For medication refills, you need to be seen and have proper blood tests done at regular intervals. For controlled substances, you need to be seen on a monthly or alternate month basis. For other refills, you need to be seen every 90 days ___

If you have any questions regarding the proposed treatment's risks or hazards or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____ Time: _____

Witness: _____ Patient: _____

(Or a person with authority to consent for the patient)

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Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

MD Medical Weight Loss and Wellness Center appreciates the confidence you have shown in choosing us to provide your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. Payment is required at the time services are rendered. We accept payments in cash, check, credit cards, HAS cards, and FSA cards.

I have read the above policy regarding my financial responsibility to MD Medical Weight Loss and Wellness Center for providing services to the above-named patient or me. I certify that the information is, to the best of my knowledge, true and accurate.

Patient Signature: _____ Date: _____

Guarantor Signature: _____

[i] 20201017