Initial Consultation Note - Sexology

Date: _____ dd / mm / yyyy

Presenting issues including sexual symptoms:

Past medical history:

Drug history:

TD related medications:

Allergies:

Past surgical history (if applicable):

Family history:

Mental & motional health:

Sex & relationships:

Fertility (past & future):

Social history:

Ageing male symptom (AMS) Score (if applicable):

Epworth Sleepiness Scale (ESS) Score (if applicable):

International Index of Erectile Function (IIEF-15) score (if applicable):

Height: _____ Weight: _____

BMI: _____ Blood pressure: _____

Waist circumference: _____

Blood test results:

Impression:

Diagnosis:

Specify below:

Next action:

Preferred treatment choice:

Is HCG recommended?

Has semen analysis been recommended?

Other comments: