CONFIDENTIAL

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Sexual History: Male

The purpose of this questionnaire is to obtain a picture of your general sexual background. Your answers may provide clues to your problems that may otherwise go unnoticed. Because this information is highly personal, it is understandable that you may be concerned about what you share. All answers are confidential. No one is permitted to see your record without your permission.

Name _____ Date _____

Relationship status: ☐single ☐divorced ☐married ☐separated ☐widowed ☐other _____

Sexual identity: ☐straight ☐gay ☐bi ☐trans ☐other _____

Living: ☐alone ☐with spouse ☐cohabiting ☐roommate ☐with parents ☐other _____

Please give your age for your FIRST experience of the following:

erotic dream_____ masturbation_____ orgasm_____ sexual feelings_____

first date_____ wet dream_____ sexual intercourse_____

Indicate whether you have difficulties with: ☐erections ☐ejaculations ☐orgasms

If you use a prescription for erections, indicate what you use:_____

	more than once daily	once daily	2-3 times weekly	once weekly	1-2 times monthly	less than once monthly
I think about sex:	☐	☐	☐	☐	☐	☐
I prefer to have sex:	☐	☐	☐	☐	☐	☐
I actually have sex:	☐	☐	☐	☐	☐	☐

Please take some time to think about and answer the following. Please use more paper if you need more space.

How you feel about self-pleasuring (masturbation), including frequency and pattern:_____

_____

_____

Describe your orgasm experiences (e.g., alone, with partner, frustrating, enjoyable, guilt, disgust, etc.):_____

_____

_____

Describe your current sex life (e.g., intercourse, masturbation, what arouses you, frequency, partners, etc.):_____

_____

_____

As you reflect upon your childhood, what were the messages you received about being sexual as a male?_____

_____

_____

How do you feel those messages may have influenced your present sexual experience?_____

_____

_____

How do you feel about your body as an adult?_____

_____

_____

Describe your history of sexual relationships, including number of partners, sexual activities experienced, and issues and conflicts encountered in your intimate relationships:

_____

_____

_____

Describe your feelings about being sexual with your present partner. (If you do not have a sexual partner at this time, describe your feelings about being sexual with a possible partner.)

_____

_____

_____

Indicate any of the following which are sexually arousing for you:

☐erotic/porn magazines	☐erotic/porn videos	☐fantasy during masturbation	☐commercial phone sex
☐message parlors	☐online sex	☐phone sex with partner	☐stranger sex (pickups)
☐prostitutes	☐female escorts	☐BDSM	☐cross dressing
☐swinging	☐exotic dance	☐sex/swing clubs	☐voyeurism
☐exhibitionism	☐public sex	☐erotic literature	☐dirty talk

☐other: _____

Please indicate whether you use any of the following.

alcohol:	☐beer	☐wine	☐hard liquor	
tobacco:	☐cigarettes	☐cigars	☐chew	
recreational drugs:	☐marijuana	☐ecstacy	☐cocaine	☐meth
	☐mushrooms	☐heroin	☐other_____	

Have you ever contracted a sexually transmitted disease? If so, please indicate which one, and the treatment outcome:

_____

Please provide the name, address, and phone of the following:

Psychotherapist_____

Primary care physician_____

Urologist_____

Endocrinologist_____

Other_____

Other_____

Please list any known medical conditions (e.g., diabetes, hypertension, heart disease, etc.):_____

_____

_____

Please list all prescribed medications currently being taken:_____

_____

_____

Describe how you want sex therapy to help your sexual life:_____

_____

_____