Sex Questionnaire

HomeopathicVibes
940 E. El Camino Real
Sunnyvale, CA 94087
harminder@homeopathicvibes.com
www.homeopathicvibes.net
Office (408)737-7100

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(Please not that this questionnaire is for therapeutic purposes only and will be confidential in all respects.)

Name (First)
_____Name(Last)_____Age_____

Marital status (Please mark one)
Married_____Single_____Widow_____Divorced_____Separated_____

Street
Adress_____City_____State_____Zip_____
_

Home
Phone_____work_____cell_____

Email_____@_____

1. Do you feel passing of semen or any abnormal fluids ○ Before Urination ○ After Urination ○ After Stool
2. Does the discharge of semen occurs during sleep? ○ Yes ○ No
3. Do you feel your penis is bent or loose towards the left side? ○ Yes ○ No
4. Do you get perfect erection before intercourse? ○ Yes ○ No
5. Do you feel weakness after the intercourse? ○ Yes ○ No
6. Are you suffering from premature ejaculation? ○ Yes ○ No
7. What is your usual duration of intercourse with current partner/wife?
   ○ Less than 5 minutes.

- More than 5 minutes.
- More than 10 minutes.

8. What was your usual duration of intercourse with previous partner if any?

- Do not apply.
- Less than 5 minutes.
- More than 5 minutes.
- More than 10 minutes.

9. Do you ever had the habit of masturbation Yes No
If so, since how long? _____

10. Are you a Vegetarian Non Vegetarian?

11. Which types of food do you like? Spicy Mild?

12. Do you have Gastric Problem ? Yes No

13. Do you have constipation? Yes No

14. Did you ever suffered from Syphilis Gonorrhea

- UTI

15. What is the approx. length of your organ?

Before erection? _____

After erection? _____

16. How many times a month you do intercourse? _____

17. How many times night discharge occurs in a week? _____

18. Do you read vulgar & obscene literature? Yes No

19. Do you watch vulgar & obscene movies? Yes No

20. Do you imagine romantic fantasies Yes No

21. Does your underwear get wet when you see nude photographs Yes No

22. Are you suffering from blood pressure Yes No

If so, whether it is? High Low

23. Do you suffer from heart problem Yes No

24. Do you sleep well Yes No

25. How many times you wake up to urinate during night?

- I don’t wake up.
- 1-3 times.
- 4-6 times.
- More than 6 times.

26. Do you play Homo sex (Man to Man) ○ Yes ○ No

27. Do you exercise daily ○ Yes ○ No

28. Do you feel pain after urination ? ○ Yes ○ No

29. Are you suffering from diabetes? ○ Yes ○ No

30. Have you ever had any road accidents? ○ Yes ○ No

If so, please furnish the full details._____

31. Do you take your food timely? ○ Yes ○ No

32. Do you take hot milk at bed time? ○ Yes ○ No

33. Is your wife older than you? ○ Yes ○ No

If so how many years? _____

34. Did you eve had any contagious disease? ○ Yes ○ No

35. How about your memory? ○ Sharp ○ Weak

36. What is the structure of your semen? ○ Thick ○ Watery

37. Did you ever took any street drugs? ○ Regular ○ occasionally ○ Never

38. Do you take any alcoholic drinks? ○ Daily ○ Occasionally ○ Never

39. Did you ever suffered from Hydrocele? ○ Yes ○ No

40. Did you ever suffered from Cystocele? ○ Yes ○ No

41. Did you ever suffered from Hernia? ○ Yes ○ No

42. If any of the have been operated upon ○ Yes ○ No

If so details_____

43. Your partner has any sexual problem? ○ Yes ○ No

44. Have you ever been treated in past? ○ Yes ○ No

○ Homeopathic ○ Allopathic ○ Ayurvedic ○ others

If so details_____

How long?_____

45. What are your expectations from our treatment?

○ I don’t expect good results.

○ I expect good results.

- I would be happy if I improve.
- I am confident.

46. Are you willing to make changes to your life style or diet modifications?

- I can not change my lifestyle.
- I have tried nothing works for me,
- I am willing to change my lifestyle if needed.
- I am willing to do what ever is needed to get results,