

LTFU

Long-Term Follow-Up Study Sibling Survey

Men's Health Questionnaire

*St. Jude Children's Research Hospital
 Children's Healthcare of Atlanta/Emory University
 Children's Hospital at Stanford
 Children's Hospital of Columbus
 Children's Hospital of Orange County
 Children's Hospital of Philadelphia
 Children's Hospital of Los Angeles
 Children's Hospital of Pittsburgh
 Children's Hospitals & Clinics of Minnesota,
 Minneapolis and St. Paul
 Children's Medical Center of Dallas
 Children's National Medical Center
 City of Hope National Medical Center
 Dana-Farber Cancer Institute/
 Children's Hospital Boston
 Loma Linda University
 Mattel Children's Hospital at UCLA
 Mayo Clinic
 Memorial Sloan-Kettering Cancer Center
 Miller Children's Hospital
 Riley Hospital for Children - Indiana University
 Roswell Park Cancer Institute
 Seattle Children's Hospital & Medical Center
 St. Louis Children's Hospital
 Texas Children's Hospital
 The Denver Children's Hospital
 Toronto Hospital for Sick Children
 UAB/The Children's Hospital of Alabama
 University of California at San Francisco
 University of Michigan - Mott Children's Hospital
 University of Minnesota*

The LTFU Men's Health Study
is funded by



Puberty, sexual development, infertility, and quality of life are important areas to study and understand in young adult survivors of pediatric cancer and other childhood illnesses. As a sibling in the Long Term Follow Up Study, your participation provides valuable information used to compare differences among survivors of childhood cancer and other serious childhood illnesses and those not affected with childhood cancer. In a survey we sent you previously, you indicated your interest in participating in a study with this subject matter. Questions like these have already been asked of the siblings of female cancer survivors in the LTFU cohort. Important findings came from the female health questionnaire - for example the risk of premature menopause in female survivors of pediatric cancer and other childhood illnesses. This finding has been used to change clinical practice and counseling to female survivors of pediatric cancer and other childhood illnesses.

So, now it is your turn to teach us more about the health of male survivors of pediatric cancer and other childhood illnesses. Participation in this aspect of the study involves answering a series of questions that will take approximately 30 minutes to complete. You may feel these questions are very personal. Please be reassured your responses will remain confidential. We appreciate your willingness to answer this questionnaire.

Sincerely,

The LTFU study staff

Today's date:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Please! Do not mark below this line

Survey #007

1668243796

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

Please follow these rules in completing this questionnaire. If you have any questions about completing this questionnaire, please call 1-800-775-2167.

1. Use a black ballpoint pen or a number 2 black pencil. Do not use a felt-tip or roller-ball pen. These may cause smudging. If you must erase answers, erase them completely.
2. When marking boxes, make an x inside the box.
3. Make no stray marks of any kind. Please keep the form as clean as possible.
4. Written responses must stay within the boxes provided.

GENERAL HEALTH QUESTIONS

A1. Have you seen a physician for a routine physical (not due to a serious or severe medical problem) in the last year?

Yes

No → **Go to Question B1.**

A2. If yes, in the last year have you seen . . .
(Mark all that apply)

General Practitioner (such as a family practice or internal medicine doctor)

Other Specialist (such as a cardiologist, endocrinologist, etc.)

If Other Specialist, what kind?

RELEVANT MEDICAL HISTORY

Some medical problems or their treatments can interfere with men's health. Below are some questions on specific medical problems.

B1. Have you been diagnosed with any of the following medical problems?

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Obsessive Compulsive Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Other Major Psychiatric Illness (for example, schizophrenia or paranoia) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Spinal injury | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Prostate disease (enlarged prostate, prostate surgery, prostate cancer) | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, what prostate problem(s)?

Please! Do not mark below this line

B2. Have you ever had problems with addiction to alcohol or drugs? Yes No

If yes, with what substance?

Alcohol Drugs

If yes to drugs, please specify which drugs.

B3. Have you ever had any of the following surgeries?

a. Prostate surgery Yes No

b. Pelvic surgery Yes No

c. Penis surgery Yes No

d. Testicular surgery Yes No

If yes to any of these surgeries, what kind of surgery(ies) did you have and why?

Testosterone Therapy

Testosterone is the male hormone made in the testes. It can be given to patients to start puberty (puberty is defined as the physical changes that allow a boy's body to change into a man's body) or can be used in older males who have low blood levels of testosterone.

B4. Have you ever been treated with testosterone?

Yes

No **→ Go to Question B11, next page.**

I don't know

B5. Were you treated with testosterone therapy during puberty (puberty in boys is typically around age 11 and leads to increase in size of the testes, growth of the penis, development of pubic hair, underarm hair and facial hair)?

Yes

No

I don't know

B6. Are you currently on testosterone?

Yes

No

B7. How have you received testosterone treatments? **(Mark all that apply)**

Injections (shots)

Skin Patch

Pills

Inside the mouth patch

Gel

B8. At what age did you start testosterone?

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Age in years

B9. If you took testosterone and it was discontinued, at what age did you stop taking testosterone?

--	--

Age in years

B10. If you stopped taking testosterone, why did you stop? **(Mark all that apply)**

I stopped the medicine because I did not like taking the medicine

My doctor told me to stop

I no longer had a prescription for the medicine

Other reason

If Other reason, explain.

Erectile Dysfunction Therapy

Erectile dysfunction is a sexual problem characterized by the inability to develop or maintain an erection of the penis. Treatment for erectile dysfunction can include medicines taken by mouth, medicines that can be given as injections, mechanical devices like pumps, and surgery.

B11. Have you ever received treatment for erectile dysfunction?

Yes

No → **Go to Question C1.**

B12. Have you ever been treated with a medicine for erectile dysfunction - like Viagra, Cialis, Levitra, Muse, Edex or Caverject?

Yes

No

If yes, what medicine(s)?

B12a. When did you begin treatment for erectile dysfunction?

Month (mm)

Year (yyyy)

B12b. Are you currently on treatment for erectile dysfunction?

Yes

No

B13. Have you ever had surgery for erectile dysfunction?

Yes

No

If yes, what surgery(ies)?

B13a. Date of First Erectile Dysfunction Surgery

Month (mm)

Year (yyyy)

B14. Have you ever had other medical treatment for erectile dysfunction (e.g., mechanical pump)?

Yes

No

If yes, what treatment(s)?

B14a. Date of First Medical Therapy for Erectile Dysfunction

Month (mm)

Year (yyyy)

PUBERTY AND SEXUAL DEVELOPMENT

The next set of questions will ask about your perceptions of your pubertal development, sexual development, and quality of life compared to others your age. You may feel these questions are personal. Please be reassured your responses will remain confidential.

C1. Was the onset of your puberty . . . (*The onset of puberty in males is characterized by development of pubic hair, increase in size of testes and increase in size of penis.*)

Early compared to others your age

Normal compared to others your age

Late compared to others your age

C2. Have you ever ejaculated? (*Ejaculation is the ejecting of semen from the penis. Ejaculation may occur during intercourse, masturbation or spontaneously during sleep - a nocturnal emission or "wet dream".*)

Yes

No

If yes, at what age did you first ejaculate?

Age in years

C3. Have you had sexual intercourse?

- Yes
- No

If yes, at what age did you first have intercourse?

--	--

Age in years

C4. My previous sexual experiences have been with . . . (Mark all that apply)

- The opposite gender - women
- The same gender - men
- I have only masturbated
- I use sexual videos, internet, etc.
- None of the above
- No reply

C5. My sexual experiences in the last year have been with . . . (Mark all that apply)

- The opposite gender - women
- The same gender - men
- I have only masturbated
- I use sexual videos, internet, etc.
- None of the above
- No reply

Fertility

C6. Have you and a partner ever tried to become pregnant?

- Yes
- No → **Go to Question D1, page 7.**

C7. Has a female partner ever had difficulty (it took more than 1 year) becoming pregnant by you?

- Yes
- No
- I don't know

C8. Were you able to have all the children you wanted to have?

- Yes → **Go to Question C10.**
- No

C8a. If no, which of you wanted more children?

- I wanted more children but my partner(s) did not
- My partner(s) wanted more children but I did not
- We both wanted more children but we could not have more

C9. If more children were wanted, what were the reasons for not having more children? (Mark all that apply)

- I was unable to father more children (male infertility)
- I had health issues that made us decide not to have more children
- My partner was not able to become pregnant (female infertility)
- My partner had other health issues that made us decide not to have more children
- My partner and I tried but could not become pregnant, we do not know the reason why
- There were issues other than health that kept us from having more children (social/financial)

If there were other issues, please specify.

C10. Have you or a female partner ever been evaluated for infertility?

- Yes
- No → **Go to Question C14, next page.**
- I don't know

C11. If you or your partner were evaluated for decreased fertility was a problem identified?

- Yes. A fertility problem was found in my partner.
- Yes. A fertility problem was found in me.
- Both of the above
- No
- I don't know

C12. Were you personally evaluated by a fertility specialist?

Yes

No → **Go to Question C14.**

If yes, which kind of physician?

If yes, how old were you at the time of evaluation?

--	--

Age in years

C13. If you were evaluated by a fertility specialist was a problem identified?

Yes

No

If yes, please specify.

C14. Have you ever had semen (sperm) analysis?

Yes

No → **Go to Question D1, next page.**

I don't know

C15. On the semen analysis was your sperm count ...

Normal

Low

I don't know

C16. On the semen analysis was the motility (movement) of your sperm ...

Normal

Low

I don't know

Continue on next page

QUALITY OF LIFE / SYMPTOMS

Quality of life is important when thinking about men's health. Please choose the single best answer to each of the following questions.

D1. In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

The following questions are about activities you might do during a typical day. In the past 4 weeks, has your health limited you in these activities? If so, how much?

D2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

D3. Climbing several flights of stairs

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

During the past 4 weeks, how often have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

D4. Accomplished less than you would like

- All of the time
- Most of the time
- Some of the time
- Little of the time
- None of the time

D5. Were limited in the kind of work or other activities

- All of the time
- Most of the time
- Some of the time
- Little of the time
- None of the time

During the past 4 weeks, how often have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

D6. Accomplished less than you would like

- All of the time
- Most of the time
- Some of the time
- Little of the time
- None of the time

D7. Did work or other activities less carefully than usual

- All of the time
- Most of the time
- Some of the time
- Little of the time
- None of the time

D8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

These questions are about how you have felt during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

D9. Have you felt calm and peaceful?

- All of the time
- Most of the time
- Some of the time
- Little of the time
- None of the time

D10. Did you have a lot of energy?

- All of the time
- Most of the time
- Some of the time
- Little of the time
- None of the time

D11. Have you felt downhearted and depressed?

- All of the time
- Most of the time
- Some of the time
- Little of the time
- None of the time

D12. During the past 4 weeks, how often has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

- All of the time
- Most of the time
- Some of the time
- Little of the time
- None of the time

Please indicate how true each statement has been for you during the past 7 days.

Mark only one answer for each problem and try not to skip any items.

	Not at all	A little bit	Somewhat	Quite a bit	Very much
E1. I feel fatigued.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E2. I feel listless ("washed out")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E3. I have trouble <u>starting</u> things because I am tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E4. I have trouble <u>finishing</u> things because I am tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E5. I am able to do my usual activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E6. I am frustrated by being too tired to do the things I want to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E7. I have to limit my social activity because I am tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SEXUAL ACTIVITY

The following are questions commonly used by doctors to assess sexual function in males. They are standardized questions asked in a standardized fashion.

These questions are sensitive and personal. Some questions ask about your own experiences, thoughts, and feelings, while others ask about your intimate relationships. Please answer each question honestly and accurately. Be assured that your responses are totally confidential.

F1. Have you been sexually active in the PAST YEAR (alone or with a partner)?

- Yes → Go to Question F3, next page.
- No

F2. I have not been sexually active in the last year because . . . (Mark all that apply)

- I have never been sexually active
- I am too tired
- I am not interested
- I have a physical problem that makes sexual relations difficult or uncomfortable
- My partner is not interested
- My partner is too tired
- My partner has a physical problem that makes sexual relations difficult or uncomfortable
- I do not have a partner at this time
- Other

If Other, please specify.

→ Go to Question F4, next page.

F3. Have you been sexually active in the PAST MONTH (alone or with a partner)?

- Yes
- No

F4. In the PAST MONTH, how frequently have you had sexual thoughts, urges, fantasies, or erotic dreams? (Please mark the one item that is closest to your experience.)

- Not at all
- Once
- 2 or 3 times
- Once a week
- 2 or 3 times a week
- Once a day
- More than once a day

F5. Using the scale below, how frequently have you felt an interest or desire to engage in the following specific activities in the PAST MONTH?

(This question is about your desire to engage, not about how you feel during sexual activity.)

(For each item, please mark the response that is closest to your experience):

	Not at all	Once	2 to 3 times	Once a week	2 to 3 times per week	Once a day	More than once a day
a. Dreams or fantasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Masturbation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Touching, hugging, holding, kissing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Petting or foreplay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Intercourse (penetration with a partner)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If Other, please specify.

F6. How frequently have you become aroused by the following sexual activity in the PAST MONTH?

(By arousal, we mean the physical and emotional responses in your body and mind that tell you that you are feeling sexual.)

(For each item, please mark the response that is closest to your experience):

	Not at all	Once	2 to 3 times	Once a week	2 to 3 times per week	Once a day	More than once a day
a. Dreams or fantasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Masturbation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Touching, hugging, holding, kissing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Petting or foreplay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Intercourse (penetration with a partner)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If Other, please specify.

F7. In the PAST MONTH, have you felt pleasure from any sexual activity?

- I have had no sexual activity in the past month
- I have not felt any pleasure
- Seldom, less than 25% of the time
- Sometimes, about 50% of the time
- Usually, about 75% of the time
- Always felt pleasure

Continue on next page

F8. Using the scale below, how frequently have you engaged in the following activities in the PAST MONTH?

(For each item, please mark the response that is closest to your experience):

	Not at all	Once	2 to 3 times	Once a week	2 to 3 times per week	Once a day	More than once a day
a. Dreams or fantasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Masturbation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Touching, hugging, holding, kissing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Petting or foreplay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Intercourse (penetration with a partner)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If Other, please specify.

F9. In the PAST MONTH, how often have you reached orgasm (ejaculation) during sexual activity?

- I have had no sexual activity in the last month
- I have not experienced orgasm
- Seldom, less than 25% of the time
- Sometimes, about 50% of the time
- Usually, about 75% of the time
- I always experienced orgasm

F10. When you have orgasms (ejaculations), how intense have they been in the PAST MONTH?

- I have had no sexual activity in the last month
- I have had no orgasms in the last month
- My orgasms were very mild
- My orgasms were fairly mild
- My orgasms were fairly strong
- My orgasms were very strong

F11. How easy or difficult has it been for you to have orgasms (ejaculations) in the PAST MONTH?

- I have had no sexual activity in the last month
- I have had no orgasms in the last month
- It was **very difficult** to have orgasms; it took a long time and a lot of concentration
- It was **fairly difficult**; it took a while
- It was **fairly easy**
- It was **very easy**

Continue on next page

F12. How frequently in the PAST MONTH have you had the problems listed below? ALSO, MARK THE BOX IN THE LAST COLUMN if the problem stops your sexual activity.

	Frequency					Does the problem stop your current sexual activity?	
	Not at all	Seldom, less than 25% of the time	Sometimes, about 50% of the time	Usually, about 75% of the time	Always	Yes	No
a. Difficulty getting an erection.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Lack of sexual interest or desire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Losing an erection during sexual activity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Delayed ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Anxiety about your sexual performance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Unable to achieve orgasm.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Pain during penetration or intercourse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Other problem with sexuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If Other, please describe.

F13. Please rate how interested you have been in sexual thoughts, feelings, or actions in the PAST MONTH by marking a number from 0 to 10 (0=Not at all interested, 10=Extremely interested).

0 1 2 3 4 5 6 7 8 9 10
 Not at all Interested Extremely Interested

F14. Please rate the extent to which sexual activity has been satisfying for you in the PAST MONTH by marking a number from 0 to 10 (0=Not at all satisfying, 10=Extremely satisfying).

0 1 2 3 4 5 6 7 8 9 10
 Not at all Satisfying Extremely Satisfying

F15. How often did the following factors influence your sexual activity in the PAST MONTH?

	Frequency					
	I have not had a partner	Not at all	Seldom, less than 25% of the time	Sometimes, about 50% of the time	Usually, about 75% of the time	Always
a. My own health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. My partner's health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Conflict in my relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If Other, please specify.

F16. Are you currently in a married or partner relationship that could be sexual?

NO, I do not have a possible partner **→ Go to Question G1.**
 YES, I am married or have a partner, and we HAVE been sexually active this past year
 YES, I am married or have a partner, but we HAVE NOT been sexually active this past year

F17. Over the past 4 weeks, how frequently have you been able to communicate your sexual desires or preferences to your partner?

I have been unable to communicate my desires or preferences
 Seldom, less than 25% of the time
 Sometimes, about 50% of the time
 Usually, about 75% of the time
 I was always able to communicate my desires or preferences

F18. Overall, how satisfied have you been with your sexual relationship with your partner?

- Very dissatisfied
- Somewhat dissatisfied
- Neither satisfied nor dissatisfied
- Somewhat satisfied
- Very satisfied

F19. Over the past 4 weeks, how satisfied have you been with your sexual relationship with your partner?

- Very dissatisfied
- Somewhat dissatisfied
- Neither satisfied nor dissatisfied
- Somewhat satisfied
- Very satisfied

F20. Overall, how satisfied do you think your partner has been with your sexual relationship?

- Very dissatisfied
- Somewhat dissatisfied
- Neither satisfied nor dissatisfied
- Somewhat satisfied
- Very satisfied

F21. Over the past 4 weeks, how satisfied do you think your partner has been with your sexual relationship?

- Very dissatisfied
- Somewhat dissatisfied
- Neither satisfied nor dissatisfied
- Somewhat satisfied
- Very satisfied

F22. Over the past 4 weeks, please rate how satisfied you have been with your ability to share warmth and intimacy with your partner by marking a number below from 0 to 10 (0=Not at all satisfied, 10=Extremely satisfied).

- 0 1 2 3 4 5 6 7 8 9 10

Not at all
Satisfied

Extremely
Satisfied

F23. Over the past 4 weeks, please rate how comfortable you have been with touching, hugging or holding your partner by marking a number from 0 to 10 (0=Not at all comfortable, 10=Extremely comfortable).

- 0 1 2 3 4 5 6 7 8 9 10

Not at all
Comfortable

Extremely
Comfortable

ERECTILE FUNCTION

These questions are specifically about erectile function and are frequently used by doctors to determine adequacy of erectile function and patient response to erectile treatments. Questions G1 to G15 are in reference to the last 4 weeks . . .

Please pick the single best answer

G1. In the past 4 weeks, how often were you able to get an erection during sexual activity?

- No sexual activity **→ Go to Question G11, next page.**
- Almost never/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/always

G2. In the past 4 weeks, when you had erections with sexual stimulation, how often were your erections hard enough for penetration?

- Almost never/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/always

G3. In the past 4 weeks, when you attempted sexual intercourse, how often were you able to penetrate (enter) your partner?

- Did not attempt intercourse → Go to Question G9.
- Almost never/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/always

G4. In the past 4 weeks, during sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

- Almost never/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/always

G5. In the past 4 weeks, during sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

- Extremely difficult
- Very difficult
- Difficult
- Slightly difficult
- Not difficult

G6. In the past 4 weeks, how many times have you attempted sexual intercourse?

- One to two attempts
- Three to four attempts
- Five to six attempts
- Seven to ten attempts
- Eleven+ attempts

G7. In the past 4 weeks, when you attempted sexual intercourse, how often was it satisfactory for you?

- Almost never/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/always

G8. In the past 4 weeks, how much have you enjoyed sexual intercourse?

- No enjoyment
- Not very enjoyable
- Fairly enjoyable
- Highly enjoyable
- Very highly enjoyable

G9. In the past 4 weeks, when you had sexual stimulation or intercourse, how often did you ejaculate?

- Almost never/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/always

G10. In the past 4 weeks, when you had sexual stimulation or intercourse, how often did you have the feeling of orgasm or climax?

- Almost never/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/always

G11. In the past 4 weeks, how often have you felt sexual desire?

- Almost never/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/always

G12. In the past 4 weeks, how would you rate your level of sexual desire?

- Very low/none at all
- Low
- Moderate
- High
- Very high

G13. In the past 4 weeks, how satisfied have you been with your overall sex life?

- Very dissatisfied
- Moderately dissatisfied
- About equally satisfied and dissatisfied
- Moderately satisfied
- Very satisfied

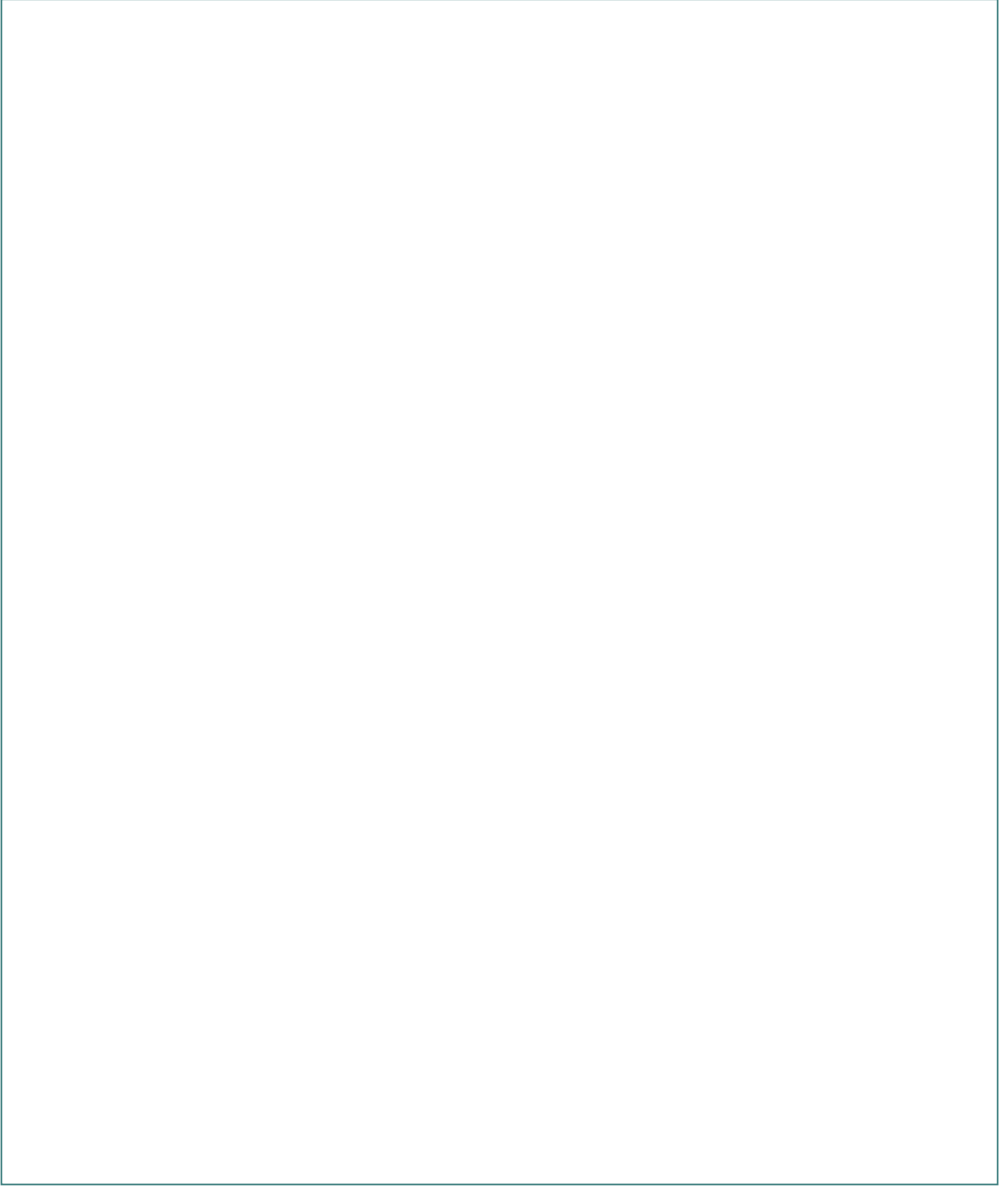
G14. In the past 4 weeks, how satisfied have you been with your sexual relationship with your partner?

- Very dissatisfied
- Moderately dissatisfied
- About equally satisfied and dissatisfied
- Moderately satisfied
- Very satisfied

G15. In the past 4 weeks, how do you rate your confidence that you could get and keep an erection?

- Very low
- Low
- Moderate
- High
- Very high

**We are always interested in your input in the follow-up study.
Use this space for any additional comments you may have:**



Please! Do not mark below this line

When you have completed this questionnaire please return it to us in the enclosed envelope.

Mail to:

LONG-TERM FOLLOW-UP STUDY
St. Jude Children's Research Hospital
Department of Epidemiology
Mail Stop 735
262 Danny Thomas Place
Memphis, TN 38105-3678

Thank you!

