



Following is a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help us understand what is important to you about your sex life. Please mark the answers that best answers your sexuality over the past six months.

**Please answer ALL questions as best you can.**

**Do you experience:**

	Always	Usually	Sometimes	Seldom	Never
1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you climax (have an orgasm) when having sexual intercourse with your partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel sexually excited (turned on) when having sexual activity with your partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How satisfied are you with the variety of sexual activities in your current sex life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you feel pain during sexual intercourse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you incontinent (leak urine) with sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does fear of incontinence (either stool or urine) restrict your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum, or vagina falling out)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your partner have a problem with erections that affects your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your partner have a problem with premature ejaculation that affects your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Much Less Intense</b>	<b>Less Intense</b>	<b>Same Intensity</b>	<b>More Intense</b>	<b>Much More Intense</b>
12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>