Consultation Form

Name: _____ **D.O.B:** ____/____/____ **Age**:____ **Height**:____

Sexual Health Questions
(Please answer honestly)

What are you hoping to benefit from this treatment? _____

_____

Have you ever taken any ED medications? Y / N **If yes, which one?** _____

Did they work for you? Y / N

Are you currently on any ED medications? Y / N **If yes, which one?** _____

How long have you been on ED medication? _____ **Days Months Years**

When was your last physical exam? _____/_____/_____

On average how many times a month are you sexually active? _____

On average how many times a night do you get up to urinate? _____

Please initial that you are in understanding of the content you have received prior to your consultation.

_____ I have read the GainsWave post treatment form and will address all questions in my consultation.

_____ I certify that all the information I have given is correct to the best of my knowledge. I will not hold my doctor or any member of the staff for any errors or omission that I may have made in the completion of this form.

_____ I understand that results may vary and that I should allow 12 weeks after my last treatment to see any improvements.

_____ I will allow a topical numbing agent to be applied 20 minutes before service.

Physician's Note

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