TYKS Turku University Hospital

Sexual symptom questionnaire

This document is designed to be printed. It includes sections to be filled.

Date:

Name:

Date of birth:

Answer the questions by circling the answer which best describes your situation!

1. In the past month, I have experienced sexual desire

   1 2 3 4 5

   daily sometimes not at all

2. I have pain in my external genitalia / vagina / lower abdomen that hinder my sex life

   1 2 3 4 5

   not at all sometimes every time

   Pain intensity: 0 1 2 3 4 5 6 7 8 9 10

   no pain worst pain possible

3. I have other pains or diseases or stress that affects my quality of life

   1 2 3 4 5

   not at all some several

4. I experience sexual pleasure

   1 2 3 4 5

   whenever I want sometimes never

5. My partner/partners have sexual dysfunction or there are problems in my intimate relationship that affect my sex life

1	2	3	4	5
not at all		to some extent		significantly

6. As a whole, I am happy with my sex life

1	2	3	4	5
completely		to some extent		not at all