



Female Sexual Dysfunction Evaluation

Patient Name: _____

Date: ___/___/___

MRN: _____

Below is a list of feelings and problems that women sometimes have concerning their sexuality. Please read each item carefully and check the box that best describes HOW OFTEN THAT PROBLEM HAS BOTHERED YOU OR CAUSED YOU DISTRESS DURING THE PAST 7 DAYS INCLUDING TODAY.

		0 Never	1 Rarely	Occasionally	3 Frequently	4 Always
1	Do you have pain with intercourse					
2	Distressed about your sex life					
3	Unhappy about your sexual difficulties					
4	Guilty about sexual difficulties					
5	Frustrated by your sexual partner					
6	Stressed about sex					
7	Inferior because of sexual problems					
8	Worried about sex					
9	Sexually inadequate					
10	Regrets about your sexuality					
11	Embarrassed about sexual problems					
12	Dissatisfied with your sex life					
13	Angry about your sex life					
14	Bothered by low sexual desire					

SCORE: _____

FSDS-R Questionnaire: For the 14-item FSDS-R, women rated each item in terms of frequency from 0 (never) to 4 (always). Items were summed to create a total score ranging from 0 to 52, with higher scores indicating more sexually related distress.