

## Appendix: Peyronie's Disease Survey

Based on responses to particular items, not all respondents were asked all questions, according to skip patterns. Additionally, some of the questions may have looped back based on number of symptoms/doctors reported, etc.

<b>SCREENING QUESTIONS</b>		<b>RESPONSES</b>
<b>Asked on Phase I survey (screener) and confirmed in Phase II survey</b>	<b>Lump or bump <u>under</u> the skin of non-erect penis (not including genital warts, pimples, or blisters)</b>	Yes, No
	<b>Unusual firmness or hardened tissue <u>under</u> the skin of non-erect penis (not including genital warts, pimples, or blisters)</b>	Yes, No
	<b>Lump/bump, firmness, or hardened tissue affect the shape of erect penis</b>	Yes, No
	<b>Development of a new <u>significant</u> bend or curve of erect penis</b>	Yes, No
	<b>Describe change in erect penis compared to when younger</b>	<input type="checkbox"/> An indentation has developed on one or both sides of penis <input type="checkbox"/> Noticeable narrowing of penis <input type="checkbox"/> Penis folds during sexual intercourse <input type="checkbox"/> Penis is shorter than it used to be. <input type="checkbox"/> The head of penis is less hard than it used to be <input type="checkbox"/> None of the above
<b>Treatment (surgery or injections) to correct the shape of penis</b>		Yes, No
<b>Diagnosis of Peyronie's disease</b>		Yes, No
<b>Diagnosed of chordee or congenital curvature of the penis</b>		Yes, No
<b>DIAGNOSIS OF PEYRONIE'S QUESTIONS</b>		
<b>Ever been told by a doctor or other healthcare professional that you have Peyronie's disease</b>		Yes, No
<b>Time of first diagnosis of Peyronie's disease</b>		Month/year
<b>Doctor or healthcare professional who made diagnosis of Peyronie's disease</b>		<input type="checkbox"/> Primary Care Physician (PCP) <input type="checkbox"/> Urologist or Urology Surgeon <input type="checkbox"/> Plastic Surgeon <input type="checkbox"/> Sexual Medicine or Sexual Health Specialist <input type="checkbox"/> Dermatologist <input type="checkbox"/> Other, specify: <input type="checkbox"/> Not sure
<b>SYMPTOM QUESTIONS</b>		
<b>Experience painful erections</b>		Yes, No
<b>Experience pain during intercourse</b>		Yes, No
<b>Difficulty achieving an erection hard enough for intercourse</b>		Yes, No
<b>Penis-related symptoms interfere with sexual activities</b>		Yes, No
<b>Questions About First Symptom Noticed and First Doctor Seen</b> (If more than one doctor/healthcare provider was seen, questions were repeated for each doctor/healthcare provide seen)		
<b>First penis-related symptom noticed</b>		<input type="checkbox"/> A lump or bump on penis <input type="checkbox"/> Hardened tissue on penis <input type="checkbox"/> A significant bend/curve in penis <input type="checkbox"/> An indentation in penis

	<input type="checkbox"/> An narrowing or hourglass shape of penis <input type="checkbox"/> Folding of penis during sex <input type="checkbox"/> Penis shorter than it used to be <input type="checkbox"/> The head of penis being less hard than it used to be <input type="checkbox"/> Painful erections <input type="checkbox"/> Pain during sexual intercourse <input type="checkbox"/> Erections not hard enough for sexual intercourse <input type="checkbox"/> Other, specify:
<b>Date when first was noticed symptom</b>	Month/year
<b>Consultation with a doctor/healthcare professional when symptom <u>first</u> noticed</b>	Yes, No
<b>Type of doctor/healthcare professional seen</b>	<input type="checkbox"/> PCP <input type="checkbox"/> Urologist or Urology Surgeon <input type="checkbox"/> Plastic Surgeon <input type="checkbox"/> Sexual Medicine or Sexual Health Specialist <input type="checkbox"/> Dermatologist <input type="checkbox"/> Other, specify:
<b>Date of consultation with first doctor</b>	Month/year
<b><u>Other</u> symptoms discussed with doctor</b>	<input type="checkbox"/> A lump or bump on penis <input type="checkbox"/> Hardened tissue on penis <input type="checkbox"/> A significant bend/curve in penis <input type="checkbox"/> An indentation in penis <input type="checkbox"/> An narrowing or hourglass shape of penis <input type="checkbox"/> Folding of penis during sex <input type="checkbox"/> Penis shorter than it used to be <input type="checkbox"/> The head of penis being less hard than it used to be <input type="checkbox"/> Painful erections <input type="checkbox"/> Pain during sexual intercourse <input type="checkbox"/> Erections not hard enough for sexual intercourse <input type="checkbox"/> Other, specify:
<b>Diagnosis given for penis-related symptoms</b>	<input type="checkbox"/> Chordee or congenital curvature of the penis <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Peyronie's disease <input type="checkbox"/> Other, specify: <input type="checkbox"/> None of the above
<b>Date of diagnosis of Peyronie's disease (if applicable)</b>	Month/year
<b>Types of treatment received from doctor</b>	<input type="checkbox"/> Acupuncture <input type="checkbox"/> Colchicine <input type="checkbox"/> Electric current therapy <input type="checkbox"/> Radiation <input type="checkbox"/> Shots or injections into the penis <input type="checkbox"/> Surgery <input type="checkbox"/> Topical gel <input type="checkbox"/> Ultrasound or laser therapy

	<input type="checkbox"/> Vacuum or stretching therapy <input type="checkbox"/> Vitamin B or Potaba <input type="checkbox"/> Vitamin E <input type="checkbox"/> Wait and see <input type="checkbox"/> Other, specify: <input type="checkbox"/> No treatment
<b>Extent to which the symptom(s) changed with treatment</b>	<input type="checkbox"/> Got better <input type="checkbox"/> Got worse <input type="checkbox"/> Stayed the same <input type="checkbox"/> Initially got better then got worse again
<b>Improvement of symptom without treatment</b>	Yes, No
<b>Still seeing doctor for penis-related symptoms</b>	Yes, No
<b>Duration of care for penis-related symptoms</b>	Months/years
<b>TREATMENT-RELATED QUESTIONS</b> (Questions were only asked if applicable based on responses to previous treatment-related items)	
<b>Number of surgeries to treat penis-related symptoms</b>	<input type="checkbox"/> Never <input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times <input type="checkbox"/> 4 times <input type="checkbox"/> 5 or more times
<b>Type of doctor/healthcare professional who performed surgery</b>	<input type="checkbox"/> Urologist or Urology Surgeon <input type="checkbox"/> Plastic Surgeon <input type="checkbox"/> Other, specify: <input type="checkbox"/> Not sure
<b>Date of surgery for penis-related symptoms</b>	Month/year
<b>Type of surgery to treat penis-related symptoms</b>	<input type="checkbox"/> Plication surgery or Nesbit procedure <input type="checkbox"/> Surgical grafting <input type="checkbox"/> Prosthetic Penile Implant <input type="checkbox"/> Other, specify: <input type="checkbox"/> Don't know <input type="checkbox"/> None of the above
<b>Correction of problem</b>	Yes, No
<b>Response to surgery</b>	<input type="checkbox"/> The symptoms came back <input type="checkbox"/> New symptoms appeared <input type="checkbox"/> The symptoms have not come back and no new symptoms have appeared
<b>Time of recurrence/new symptoms after surgery</b>	Months/years after surgery
<b>Number of <u>series</u> of shots or injections to treat your penis-related symptoms</b>	<input type="checkbox"/> None <input type="checkbox"/> 1 series <input type="checkbox"/> 2 series <input type="checkbox"/> 3 series <input type="checkbox"/> 4 series <input type="checkbox"/> 5 or more series
<b>Type of doctor/healthcare professional that administered each series</b>	<input type="checkbox"/> Primary Care Physician (PCP) <input type="checkbox"/> Urologist or Urology Surgeon <input type="checkbox"/> Plastic Surgeon <input type="checkbox"/> Sexual Medicine or Sexual Health

	Specialist <input type="checkbox"/> Dermatologist <input type="checkbox"/> Other, specify: <input type="checkbox"/> Not sure
<b>Date of series of shots or injections to treat the symptom(s) in your penis</b>	Month/year
<b>Medication received in series of shots or injections</b>	<input type="checkbox"/> Collagenase <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Interferon <input type="checkbox"/> Testosterone <input type="checkbox"/> Verapamil <input type="checkbox"/> Vitamin B or Potaba <input type="checkbox"/> Other, specify: <input type="checkbox"/> Not sure <input type="checkbox"/> None of the above
<b>Number of shots with the series</b>	<input type="checkbox"/> 1 injection <input type="checkbox"/> 2-6 injections <input type="checkbox"/> 7-12 injections <input type="checkbox"/> 13+ injections <input type="checkbox"/> Not sure
<b>Correction of problem</b>	Yes, No
<b>Response to shots</b>	<input type="checkbox"/> The symptoms came back <input type="checkbox"/> New symptoms appeared <input type="checkbox"/> The symptoms have not come back and no new symptoms have appeared
<b>Time of recurrence/new symptoms after last shot or injection</b>	Months/years after last shot of series