CAPSTONE
MEDICAL ASSOCIATES

PRP Penile Enhancement Questionnaire

Name: _____

DOB: _____/_____/_____

Address: _____

_____

Phone: _(_____)_____

Please mark reason(s) below for obtaining P-Shot:

- ☐ Erectile Dysfunction
- ☐ Maximum Growth
- ☐ Loss of Sensation
- ☐ Strength / Stronger Erection
- ☐ Peyronie's Disease
- ☐ Other: _____

_____ _____

Signature Date