Epworth Sleepiness Scale

Support services provided by MDVIP

Patient's Name _____ Today's Date _____

Age _____ Gender _____ Physician's Name _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you. Place an X in the corresponding space for each situation.

	- 0 - WOULD NEVER DOZE	- 1 - SLIGHT CHANCE OF DOZING	- 2 - MODERATE CHANCE OF DOZING	- 3 - HIGH CHANCE OF DOZING
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. a theatre or a meeting)				
A passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				
TOTAL				

SCORING: **0-12** = **Normal** | **10-12** = **Borderline** | **12-24** = **Abnormal**

TOTAL SCORE

_____

Beck Anxiety Inventory & Scoring

Support services provided by MDVIP

Patient's Name _____ Today's Date _____

Age _____ Gender _____ Physician's Name _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	- 0 - **NOT AT ALL**	- 1 - **MILDLY** It did not bother me much.	- 2 - **MODERATELY** It was very unpleasant, but I could stand it.	- 3 - **SEVERELY** I could barely stand it.
Numbness or tingling				
Feeling hot				
Wobbliness in legs				
Unable to relax				
Fear of the worst happening				
Dizzy or lightheaded				
Heart pounding or racing				
Unsteady				
Terrified				
Nervous				
Feelings of choking				
Hands trembling				
Shaky				
Fear of losing control				
Difficulty breathing				
Fear of dying				
Scared				
Indigestion or discomfort in abdomen				
Faint				
Face flushed				
Sweating (not due to heat)				
TOTAL				

MAXIMUM SCORE = 63 POINTS

0-7 = Minimal Anxiety | 8-15 = Mild Anxiety | 16-25 = Moderate Anxiety | 26-63 = Severe Anxiety

TOTAL SCORE

_____

Female Sexual Function Screener

Support services provided by MDVIP

Patient's Name _____ Today's Date _____

Age _____ Gender _____ Physician's Name _____

These questions ask about your present experience. Circle the response that best describes your own situation. Please be sure that you select only one response for each question.

A. Are you satisfied with your level of sexual desire or interest?

0. Always
1. Most Times
2. Sometimes
3. Never

B. Are you satisfied with your level of lubrication during sexual activity or intercourse?

0. Always
1. Most Times
2. Sometimes
3. Never

C. Are you satisfied with your overall sexual life?

0. Satisfied
1. Neutral
2. Dissatisfied

D. Do you experience discomfort or pain during sexual activity or intercourse?

0. Yes
1. No

SCORING: **0-3** = **No action** | **4-10** = **Assess further**

TOTAL SCORE

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