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

_____

Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____

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.

If you prefer to skip this section, please proceed to the next page.

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

_____

Name:_____ DOB:_____

Nutrition Assessment Form

Please check if you are currently taking any of the following:

☐ Multi-vitamins: brand: _____

☐ Single Vitamins (Vitamin C, E, etc): type(s): _____

☐ Calcium: type: _____ amount: _____

☐ Herbs: type(s): _____

☐ Other: _____

Food Allergies/ Intolerances: _____

_____

Please check (✓) everything below that describes your eating pattern and/or lifestyle behaviors:

	1. I eat large portions, get seconds or overfill my plate		11. I don't take time to plan healthy meals ahead
	2. I skip meals or go for longer than 5 hours between meals		12. I am tempted by family/friends to eat unhealthy foods
	3. I dine out (includes carry-out) more than 3 times a week		13. I lack the knowledge to cook healthy
	4. I frequently eat fried foods, fast foods and high fat foods		14. I never feel "full" or satisfied after eating
	5. I frequently eat sweets and desserts (candy, cakes, cookies)		15. When dieting, I go to extremes
	6. I graze (snack on food all day long while doing other things (reading, watching TV, computer work)		16. I drink less than 64 ounces (8 cups) daily (all fluids count)
	7. I eat too quickly		17. I usually drink two or more alcoholic beverages daily
	8. I am an emotional eater (I eat when I am stressed, bored, anxious…)		18. My work schedule hinders my weight loss efforts
	9. I am so busy, I forget to stop and eat		19. I would have a difficult time reducing or giving up: _____
	10. I am a "picky" eater		Other: