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

_____

Sexual Health Inventory for Men (SHIM)

Support services provided by MDVIP

Patient's Name _____ Today's Date _____

Age _____ Gender _____ Physician's Name _____

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the response that best describes your own situation. Please be sure that you select only one response for each question. OVER THE PAST 6 MONTHS:

A. How do you rate your confidence that you could get and keep an erection?

1. Very low
2. Low
3. Moderate
4. High
5. Very high

B. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

0. No sexual activity
1. Almost never or never
2. A few times (much less than half the time)
3. Sometimes (about half the time)
4. Most times (much more than, half the time)
5. Almost always or always

C. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

0. Did not attempt intercourse
1. Almost never or never
2. A few times (much less than half the time)
3. Sometimes (about half the time)
4. Most times (much more than, half the time)
5. Almost always or always

D. During sexual intercourse, how difficult was it to maintain your erection to completion or intercourse?

0. Did not attempt intercourse
1. Extremely difficult
2. Very difficult
3. Difficult
4. Slightly difficult
5. Not difficult

E. When you attempted sexual intercourse, how often was it satisfactory for you?

0. Did not attempt intercourse
1. Almost never or never
2. A few times (much less than half the time)
3. Sometimes (about half the time)
4. Most times (much more than, half the time)
5. Almost always or always

THE SEXUAL HEALTH INVENTORY FOR MEN FURTHER CLASSIFIES ED SEVERITY WITH THE FOLLOWING BREAKPOINTS: **1-7** = **Severe ED** | **8-11** = **Moderate ED** | **12-16** = **Mild to Moderate ED** | **17-21** = **Mild ED**

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: