Epworth Sleepiness Scale and Anxiety Inventory (GAD-7)

Support services provided by MDVIP

Patient's Name _____ Today's Date _____

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 _____

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

Sexual Health Screener

Support services provided by MDVIP

Patient's Name _____ Today's Date _____

Sexual health is an important part of an individual's overall physical and emotional well-being. Fortunately, there are different treatment options for the many common issues that arise. This questionnaire is designed to help us identify if you may be experiencing such challenges. 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.

If you prefer to skip this section, you may move on to the next page.

For MEN:

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

C. During sexual intercourse, how difficult was it to maintain your erection throughout the encounter?
   1. Did not attempt intercourse
   2. Extremely difficult
   3. Very difficult
   4. Difficult
   5. Slightly difficult
   6. Not difficult

D. When you attempted sexual intercourse, how often was it satisfactory for you?
   1. Did not attempt intercourse
   2. Almost never or never
   3. A few times (much less than half the time)
   4. Sometimes (about half the time)
   5. Most times (much more than, half the time)
   6. Almost always or always

For WOMEN

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. Very Satisfied
1. Satisfied
2. Neutral
3. Not Satisfied

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

0. Frequently
1. Sometimes
2. No

Name:_____ Date: _____

Nutrition and Activity Assessment

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		

What kinds of exercise do you enjoy most? _____

What types of exercise are you doing now? _____

How often do you exercise? _____ Are you satisfied with your routine? Yes / No

What are the biggest obstacles to exercising? _____

Do you have access to (circle all that apply):

Fitness Center/Gym
Exercise Classes
Home Exercise Equipment (list):_____
Pool
Outdoor Equipment (Bike, Kayak, Racket Equipment/Court, Golf, Other)
Team sports/League