PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	___ +	___ +	___

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: ______

10. 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	________

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ALCOHOL MISUSE / ABUSE (AUDIT C)

Patient's Name: ______________________ **Gender:** __________ **Date:** ____________

Did you have a drink containing alcohol in the past year?

- ☐ Yes
- ☐ No

If 'Yes': How often did you have a drink containing alcohol in the past year?

- ☐ Never (0 point)
- ☐ Monthly or less (1 point)
- ☐ 2 to 4 times a month (2 points)
- ☐ 2 to 3 times a week (3 points)
- ☐ 4 or more times a week (4 points)

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?

- ☐ 1 or 2 drinks (0 Point)
- ☐ 3 or 4 drinks (1 point)
- ☐ 5 or 6 drinks (2 points)
- ☐ 7 to 9 drinks (3 points)
- ☐ 10 or more drinks (4 points)

If 'Yes': How often did you have 6 or more drinks on one occasion in the past year?

- ☐ Never (0 point)
- ☐ Less than monthly (1 point)
- ☐ Monthly (2 points)
- ☐ Weekly (3 points)
- ☐ Daily or almost daily (4 points)

Total __________

Beck Anxiety Index

Patient's Name: ______________________________

Physician's Name: ______________________________ Date: ______________

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.

	NOT AT ALL	**MILDLY** It did not bother me much.	**MODERATELY** It was very unpleasant, but I could stand it.	**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)				

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Duke Activity Status Index

Patient's Name: ______________________________

Physician's Name: ______________________________ Date: ______________

Overview:

The Duke Activity Status Index is a self-administered questionnaire that measures a patient's functional capacity. It can be used to get a rough estimate of a patient's peak oxygen uptake.

Item	Activity	Yes	No
1	Can you take care of yourself (eating, dressing, bathing or using the toilet)?	2.75	0
2	Can you walk indoors such as around your house?	1.75	0
3	Can you walk a block or two on level ground?	2.75	0
4	Can you climb a flight of stairs or walk up a hill?	5.50	0
5	Can you run a short distance?	8.00	0
6	Can you do light work around the house like dusting or washing dishes?	2.70	0
7	Can you do moderate work around the house like vacuuming, sweeping floors or carrying in groceries?	3.50	0
8	Can you do heavy work around the house like scrubbing floors or lifting and moving heavy furniture?	8.00	0
9	Can you do yardwork like raking leaves, weeding or pushing a power mower?	4.50	0
10	Can you have sexual relations?	5.25	0
11	Can you participate in moderate recreational activities like golf, bowling, dancing, doubles tennis or throwing a baseball or football?	6.00	0
12	Can you participate in strenuous sports like swimming, singles tennis, football, basketball or skiing?	7.50	0

Duke activity status index =

= SUM(values for all 12 questions)

Interpretation:

- maximum value 58.2
- minimum value 0

estimated peak oxygen uptake in mL/min =

= (0.43 * (duke activity status index)) + 9.6

References:

Hltaky MA Boineau RE et al. A brief self-administered questionnaire to determine functional capacity (The Duke Activity Status Index). Am J Cardio. 1989; 64: 651-654

Epworth Sleepiness Scale

Patient's Name: ______________________________

Physician's Name: ______________________________ Date: ______________

Your age: (Yr) ______________ Gender: ☐ Male ☐ Female

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.

Use the following scale to choose the <u>most appropriate number</u> for each situation:

0 = Would <u>never</u> doze
1 = <u>Slight</u> chance of dozing
2 = <u>Moderate</u> chance of dozing
3 = <u>High</u> chance of dozing

Situation	**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	

MEDICAL CLINIC OF BELLAIRE, P.A.
DR. ESTHER GUY

Name____ DOB____________

Multi-Cancer Early Detection Test now available at our practice
MDVIP offers a discount cancer screening through Galleri for $749.00 (Reg-$949.00)
This multi-cancer early detection test does not replace normal annual screening for breast or recommended screenings for colorectal cancer.

Please circle yes or no to the following questions:

1. Are you over the age of 50? Yes No

2. Do you have a family history of cancer? Yes No

3. Would you be interested in a blood test that can detect 50 types of cancer as early as stage 1? Yes No

4. Would you like to discuss this test with your doctor at your AWP? Yes No

*****Payment plans are available.
*****This test does qualify for coverage with your HSA and FSA funded plans.

I, *(name of patient)* ________________________________, acknowledge and agree that I have reviewed all of the information above.

____
Patient Signature

____
Date