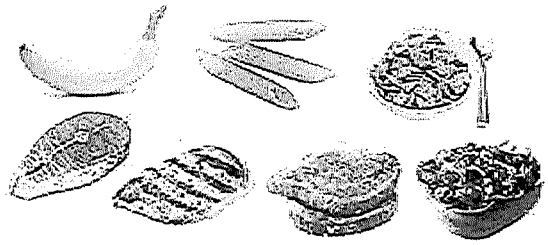
MDVIP HEALTH ASSESSMENT

Your Eating Habits

When choosing foods, do you tend to eat high-fat or low-fat items?

Mark an 'X' along the line that best indicates your answer.



Low-fat foods

Some examples of low-fat foods:

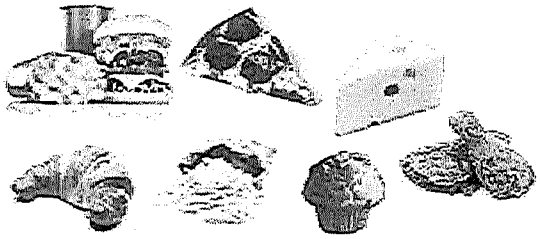
- Salad, fruits and vegetables
- Pasta and rice
- Wholegrain breakfast cereals
- Bread
- Lean meat
- Fish
- Eggs
- Low-fat dairy products (incl. skimmed and semi-skimmed milk)
- Low-fat spread

Half and half

Some examples of high-fat foods:

- Most carry-out and fast foods (pizza, curry, Chinese)
- Ready meals
- Fried foods (incl. fried breakfast)
- Crisps and chips
- Cakes, muffins and biscuits
- Donuts
- Pasties, pies and sausage rolls
- Sausages and burgers
- Hard cheese, butter and mayo
- Regular milk and milk shakes
- Chocolate bars

High-fat foods

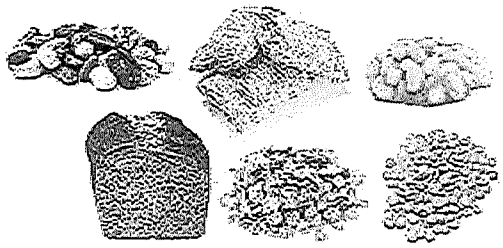


MDVIP HEALTH ASSESSMENT

Your Eating Habits

When choosing foods, do you tend to eat high-fiber or low-fiber items?

Mark an 'X' along the line that best indicates your answer.



High-fiber foods

Some examples of high-fiber foods:

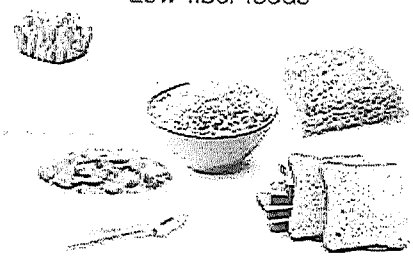
- Wholegrain and brown bread
- Brown pasta and rice
- Nuts, lentils and beans
- Most fruits and vegetables
- Oats
- Wholegrain breakfast cereals (Shredded Wheat, Fruit and Fiber)
- Jacket potatoes

Half and half

Some examples of low-fiber foods:

- White bread
- White pasta, rice and noodles
- Some breakfast cereals (Corn Flakes, Rice Krispies and CoCo Pops)
- Chips and crisps
- Potatoes without the skin
- Ready and microwave meals

Low-fiber foods



MDVIP HEALTH ASSESSMENT

Your Eating Habits

When choosing foods, do you tend to eat high-salt or low-salt items?

Mark an 'X' along the line that best indicates your answer.

Low-salt foods

Some examples of low-salt foods:

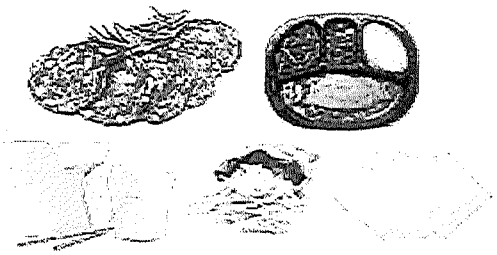
- Fruits and vegetables
- Grilled chicken
- Grilled fish
- Plain pasta
- Unsalted nuts
- Eggs
- Mozarella and most soft cheeses

Half and half

Some examples of high-salt foods:

- Most ready and microwave meals
- Cured, smoked and preserved cold meats
- Many canned soups and foods
- Many carry-out and fast foods (pizza, Chinese, burgers)
- Chips and crisps
- Corn flakes
- Shop-bought bakery products
- White bread
- Ketchup
- Creamy sauces in restaurants

High-salt foods



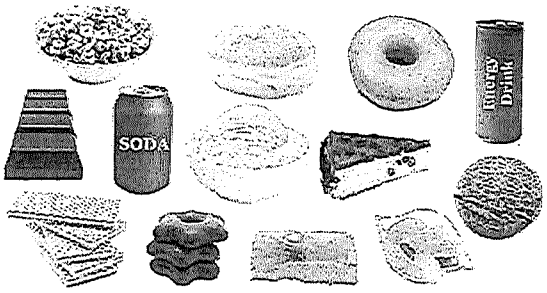
MDVIP HEALTH ASSESSMENT

Your Eating Habits

How often do you eat sweet, sugary foods in a typical day?

Please check ONE answer only.

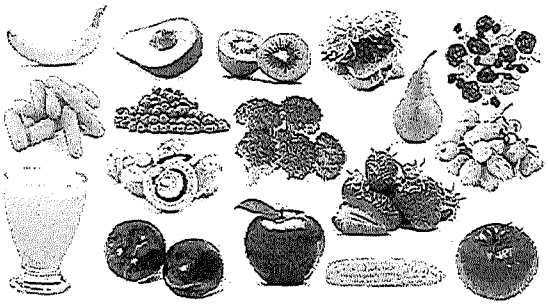
- ☐ 5 times a day or more
- ☐ 4 times a day
- ☐ 3 times a day
- ☐ Twice a day
- ☐ Once a day
- ☐ Less than once a day, or never



On a typical day how many servings of fruits and vegetables do you eat?

Please check ONE answer only.

- ☐ None
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7 or more

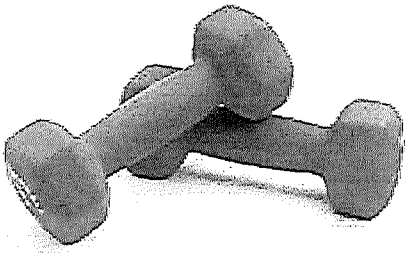


MDVIP HEALTH ASSESSMENT

Your Physical Activity

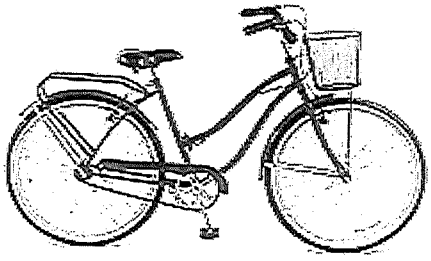
Think about a typical 7-day week. How much of the following exercise do you get?

Please write the number of days of exercise and the average time (in minutes) spent exercising.



Vigorous physical activities
Like heavy lifting, digging, aerobics or fast cycling

Number of days: ☐ Average time each day (mins): ☐



Moderate physical activities
Like carrying light loads, cycling at regular pace or doubles tennis

Number of days: ☐ Average time each day (mins): ☐

Walking for at least 10 minutes
Includes walking at work, home or for any exercise or leisure

Number of days: ☐ Average time each day (mins): ☐

MDVIP HEALTH ASSESSMENT

Sleep

How many hours of sleep do you get on a typical weekday night and a typical weekend or non-working night?

Write down the hours and minutes of sleep that you get.

How many hours of sleep do you get on a typical weekday/work-night?

Hours

Minutes

How many hours of sleep do you get on a typical weekend/non-work night?

Hours

Minutes

MDVIP HEALTH ASSESSMENT

Sleep

How often do you find you have difficulty falling asleep or difficulty staying asleep at night?

Please check ONE answer only.

- ☐ I have these problems most nights
- ☐ I have these problems at least 2 or 3 times a week
- ☐ I have these problems about once a week
- ☐ I occasionally have these problems, but less than once a week
- ☐ I virtually never have these sort of problems

On a regular week day when you wake up in the morning and have gotten yourself out of bed and ready for the day ahead, how rested and refreshed do you feel?

Please check ONE answer only.

- ☐ Exhausted
- ☐ Very tired
- ☐ Quite tired
- ☐ A little tired
- ☐ Completely rested

Overall, how satisfied are you with the amount and quality of the sleep that you usually get?

Please check ONE answer only.

- ☐ Very unsatisfied
- ☐ Unsatisfied
- ☐ OK
- ☐ Satisfied
- ☐ Very satisfied

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 _____

MDVIP HEALTH ASSESSMENT

Your Tobacco Usage

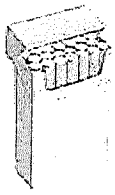
Do you smoke or use chewing tobacco?

Please check ONE answer only.

- ☐ Yes, I currently smoke
- ☐ No, I gave up less than 10 years ago
- ☐ No, I gave up more than 10 years ago
- ☐ No, I've never smoked or chewed tobacco *(if you select this answer, skip the next question)*

Which of the following tobacco products do you/did you use? Check the options below.

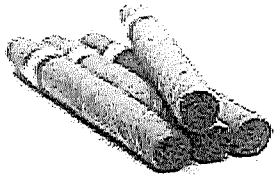
Please write how much tobacco you used or currently use and how long you have used it.



Cigarettes

In a single day, how many cigarettes do you/did you smoke?

How many years have you smoked?



Cigars

In a single day, how many cigars do you/did you smoke?

How many years have you smoked?

Pipes

In a single day, how many ounces of tobacco do you/did you smoke?

How many years have you smoked?

Chewing Tobacco

In a single day, how many ounces of chew or dip do you/did you use?

How many years have you smoked?

The CAGE and CAGE-AID Questionnaires

Patient's Name: _____

Physician's Name: _____ Date: _____

The CAGE and CAGE AID Questions

The original CAGE questions appear in plain type. The CAGE questions Adapted to Include Drugs (CAGE-AID) are the original CAGE questions modified by the *italicized text.*

The CAGE or CAGE-AID should be preceded by these two questions:

1. Do you drink alcohol?
2. Have you ever experimented with drugs?

If the patient has experimented with drugs, ask the CAGE-AID questions. If the patient only drinks alcohol, ask the CAGE questions.

CAGE and CAGE-AID Questions

1. In the last three months, have you felt you should cut down or stop drinking or *using drugs?*

   Yes No

2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or *using drugs?*

   Yes No

3. In the last three months, have you felt guilty or bad about how much you drink or *use drugs?*

   Yes No

4. In the last three months, have you been waking up wanting to have an alcoholic drink or *use drugs?*

   Yes No

Each affirmative response earns one point. One point indicates a possible problem. Two points indicate a probable problem.

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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 _____

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		+	+
	TOTAL:			

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

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 _____

A2663B 10-04-2005

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 _____

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 _____