Duke Activity Status Index

Patient's Name: ____________________

Physician's Name: **Deirdre McMullen M.D.** 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

The Burns Depression Checklist

Patient's Name: ______________________________

Physician's Name: Deirdre McMullen M.D. Date: ______________

Instructions: The following is a list of symptoms that people frequently have. Put a check in the space to the right that best describes how much that symptom or problem has bothered you during the past week.

		0 - Never	1 - Somewhat	2 - Moderately	3 - A lot
1.	Sadness: Have you been feeling sad or down in the dumps?				
2.	Discouragement: Does the future look hopeless?				
3.	Low self-esteem: Do you feel worthless or think of yourself as a failure?				
4.	Inferiority: Do you feel inadequate or inferior to others?				
5.	Guilt: Do you get self-critical and blame yourself for everything?				
6.	Indecisiveness: Do you have trouble making up your mind about things?				
7.	Irritability and frustration: Have you been feeling resentful and angry a good deal of the time?				
8.	Loss of interest in life: Have you lost interest in your career, your hobbies, your family, or your friends?				
9.	Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?				
10.	Poor self-image: Do you think you're looking old or unattractive?				
11.	Appetite changes: Have you lost your appetite, or do you overeat or binge compulsively?				
12.	Sleep changes: Do you suffer from insomnia and find it hard to get a good night's sleep? Or are you excessively tired and sleeping too much?				
13.	Loss of libido: Have you lost your interest in sex?				
14.	Hypochondriasis: Do you worry a great deal about your health?				
15.	Suicidal impulses: Do you have thoughts that life is not worth living or think that you might be better off dead?				

Add up your total score for the 15 symptoms and record it here: ______

It will be between 0 (if you have answered "not at all" for each of the 15 categories) and 45 (if you have answered "a lot" for each one). Use the key to interpret the score.

Total Score	Degrees of Depression
0 - 4	Minimal or no depression
5 - 10	Borderline depression
11 - 20	Mild depression
21 - 30	Moderate depression
31 - 45	Severe depression

Rate Your Plate

Patient's Name: ____________________

Physician's Name: Deirdre McMullen M.D. Date: ____________

RATE YOUR PLATE

Think about the way you usually eat. For each food topic, put a check mark in column A, B or C.

TOPIC	A	B	C
1. **GRAINS** *1 Serving* = 1 slice bread or tortilla; ½ bagel, roll, English muffin or pita; ½ cup cooked rice or pasta; 1 cup cereal	❑ **Usually eat:** less than 4 servings of grain products a day	❑ **Usually eat:** 4-5 servings of grain products a day	❑ **Usually eat:** 6 or more servings of grain products a day
2. **WHOLE GRAINS**	❑ **Usually eat:** white breads, white rice, low fiber cereals like corn flakes, rice krispies, etc.	❑ **Sometimes eat:** less than 4 servings of grain products a day	❑ **Usually eat:** whole grain breads, brown rice, whole grain cereals like oatmeal, bran cereals, Wheaties™, etc.
3. **FRUITS & VEGETABLES** *1 Serving* = ½ cup cooked or 1 med. fruit or 1 cup leafy raw vegetables or 4 oz. 100% fruit or veg. juice	❑ **Usually eat:** 1 serving or less a day	❑ **Usually eat:** 2-4 servings a day	❑ **Usually eat:** 5 or more servings a day
4. **DAIRY FOODS** *1 Serving* = 1 cup milk or yogurt; 1½-2 ounces cheese	❑ **Rarely eat or drink:** 2 or more servings of milk, yogurt, or cheese a day	❑ **Sometimes eat or drink:** 2 or more servings of milk, yogurt, or cheese a day	❑ **Usually eat or drink:** 2 or more servings of milk, yogurt, or cheese a day
5. **MEAT, CHICKEN, TURKEY OR FISH** *1 Serving* = 3 oz. (the size of a deck of cards) or 1 regular hamburger, 1 chicken breast or leg, or 1 pork chop	❑ **Usually eat:** more than 6 ounces of meat, chicken, turkey or fish per day	❑ **Sometimes eat:** more than 6 ounces of meat, chicken, turkey or fish per day	❑ **Rarely/never eat:** more than 6 ounces of meat, chicken, turkey or fish per day
6. **EATING OUT** in restaurants or getting take-out food	❑ **Usually eat out or get take-out food:** twice a week or more	❑ **Usually eat out or get take-out food:** once a week or more	❑ **Usually eat out or get take-out food:** less than once a week OR usually eat low-fat restaurant meals
7. **RED MEAT** (includes beef, hamburger, pork, lamb or veal)	❑ **Usually eat:** three times a week or more	❑ **Usually eat:** twice a week	❑ **Usually eat:** once a week or less
8. **RED MEAT CHOICES** (includes beef, hamburger, pork, lamb or veal)	❑ **Usually eat:** high-fat cuts, such as ribs, brisket, T-bone steak, prime rib, sausage, regular or lean ground beef	❑ **Sometimes eat:** high-fat cuts, such as ribs, brisket, T-bone steak, prime rib, sausage, regular or lean ground beef	❑ **Usually eat:** lean beef such as round, loin, flank, lean pork and lamb such as loin and leg, veal, ground turkey breast OR rarely/never eat meat

Patient's Name: ____________________

Physician's Name: **Deirdre McMullen M.D.** Date: ____________________

TOPIC	A	B	C
9. **COLD CUTS, HOT DOGS, BREAKFAST MEATS**	❑ **Usually eat:** salami, bologna, other cold cuts, hot dogs, bacon, sausage	❑ **Sometimes eat:** salami, bologna, other cold cuts, hot dogs, bacon, sausage	❑ **Usually eat:** roast beef, turkey breast, ham or low-fat cold cuts, low-fat hot dogs, low fat bacon/sausage
10. **CHICKEN, TURKEY, ETC.**	❑ **Usually eat:** chicken, turkey, and other poultry **with** skin	❑ **Sometimes eat:** chicken, turkey, and other poultry **with** skin	❑ **Usually eat:** chicken, turkey, and other poultry **without** skin
11. **CHICKEN AND FISH CHOICES**	❑ **Usually eat:** fried chicken and/or fried fish and shellfish	❑ **Sometimes eat:** fried chicken and/or fried fish and shellfish	❑ **Usually eat:** chicken and fish that is baked, broiled, grilled, poached, roasted, etc.
12. **MEATLESS MAIN DISHES** such as all-bean chili, bean burrito, lentil soup, meatless spaghetti sauce	❑ **Rarely eat:** meatless main dishes	❑ **Usually eat:** meatless main dishes less than twice a week	❑ **Usually eat:** meatless main dishes twice a week or more
13. **MILK**	❑ **Usually eat:** whole milk or cream	❑ **Usually eat:** 2% reduced-fat milk	❑ **Usually eat:** 1% low-fat or skim milk
14. **CHEESE** includes cheese on pizza, sandwiches, snacks and in mixed dishes	❑ **Usually eat:** regular cheese such as cheddar, Swiss and American	❑ **Sometimes eat:** regular cheese such as cheddar, Swiss and American	❑ **Usually eat:** reduced-fat or part-skim cheese OR rarely eat cheese
15. **FROZEN DESSERTS** Ice cream, etc.	❑ **Usually eat:** regular ice cream, ice cream bars/sandwiches	❑ **Sometimes eat:** regular ice cream, ice cream bars/sandwiches	❑ **Usually eat:** sherbet, sorbet, low-fat frozen yogurt or ice cream OR rarely eat frozen desserts
16. **COOKING METHOD**	❑ **Usually add:** oil, butter or margarine to the pan	❑ **Sometimes add:** oil, butter or margarine to the pan	❑ **Usually eat:** broil, bake, or steam without fats or oils or use cooking sprays (Pam)
17. **FRIED FOODS** such as french fries, egg rolls, onion rings, etc.	❑ **Usually eat:** fried foods	❑ **Sometimes eat:** fried foods	❑ **Rarely/Never eat:** fried foods
18. **SPREADS** added at the table	❑ **Usually put:** butter or stick margarine on bread, potatoes, vegetables, etc.	❑ **Usually put:** liquid or tub margarine on bread, potatoes, vegetables, etc.	❑ **Usually put:** "light" tub margarine on bread, potatoes, vegetables, etc. OR eat them plain
19. **SALAD DRESSING & MAYONNAISE**	❑ **Usually use:** regular salad dressing or mayonnaise	❑ **Sometimes use:** regular salad dressing or mayonnaise	❑ **Usually use:** light or fat-free salad dressing and mayonnaise
20. **SNACKS**	❑ **Usually eat:** regular chips, crackers and nuts	❑ **Sometimes eat:** regular chips, crackers and nuts	❑ **Usually eat:** fruit, pretzels, low-fat crackers or baked chips

Patient's Name: ______________________

Physician's Name: Deirdre McMullen M.D. ______________________ Date: ______________

TOPIC	A	B	C
21. **DESSERTS AND SWEETS**	❑ **Usually eat:** donuts, cookies, cake, pie, pastry or chocolate	❑ **Sometimes eat:** donuts, cookies, cake, pie, pastry or chocolate	❑ **Usually eat:** fruit, angel food cake, low-fat or fat-free sweets
22. **ADDED SALT**	❑ **Usually:** add salt to food when cooking or at the table	❑ **Sometimes:** add salt to food when cooking or at the table	❑ **Rarely/Never:** add salt to food when cooking or at the table
23. **SALTY SNACKS** chips, pretzels, crackers, salted nuts	❑ **Often eat:** salty snacks	❑ **Sometimes eat:** salty snacks	❑ **Rarely/Never eat:** salty snacks
24. **CANNED FOODS, FROZEN PACKAGED MEALS**	❑ **Usually:** choose regular canned/frozen/ packaged foods	❑ **Sometimes:** choose regular canned/frozen/ packaged foods	❑ **Usually:** choose low sodium canned/frozen/packaged foods OR rarely eat these foods
25. **DESSERTS AND SWEETS**	❑ **Usually eat:** high sugar desserts and sweets	❑ **Sometimes eat:** high sugar desserts and sweets	❑ **Usually eat:** low sugar desserts and sweets
26. **SODA, PUNCH, ETC** Soda, pop, fruit drink, punch, Kool-Aid™, etc.	❑ **Usually drink:** 16 oz. or more of regular (non-diet) soda, punch, etc. per day	❑ **Usually drink:** 8-15 oz. or more of regular (non-diet) soda, punch etc. per day	❑ **Usually drink:** Less than 8 oz. or more of regular (non-diet) soda, punch etc. per day
27. **BEER, WINE, LIQUOR** *1 Drink* = 12 oz. beer, 5 oz. wine, one shot of hard liquor or mixed drink with 1 shot	❑ **Often drink:** more than 1-2 alcoholic drinks in a day	❑ **Sometimes drink:** more than 1-2 alcoholic drinks n a day	❑ **Rarely/Never drink:** more than 1-2 alcoholic drinks in a day

FIND YOUR *RATE YOUR PLATE SCORE*

Total check in column A = ______________ x 1 = __________

Total check in column B = ______________ x 2 = __________

Total check in column C = ______________ x 3 = __________

TOTAL: __________

If your score is:

27-45: There are many ways you can make your eating habits healthier.

46-63: There are some ways you can make your eating habits healthier.

64-81: You are making many healthy choices.

The CAGE and CAGE-AID Questionnaires

Patient's Name: ______________________________

Physician's Name: Deirdre McMullen M.D. ______________ 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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Epworth Sleepiness Scale

Patient's Name: ______________________________

Physician's Name: Deirdre McMullen M.D. 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.

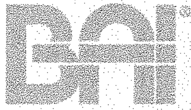
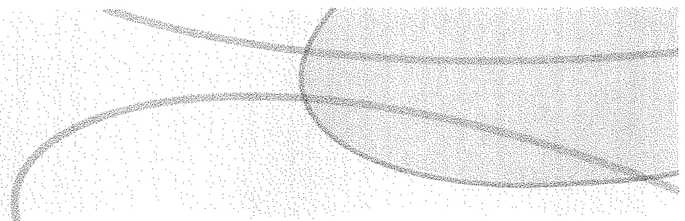
Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High 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	

Score:
0-10 Normal Range
10-12 Borderline
12-24 Abnormal

Beck Anxiety Index

Patient's Name: ______________________________

Physician's Name: Deirdre McMullen M.D. 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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Beck Anxiety Scoring

Patient's Name: ______________________________

Physician's Name: Deirdre McMullen M.D. Date: ______________

Score:

0 = Not at all

1 = Mildly

2 = Moderately

3 = Severely

Maximum score = 63 points

0-7 – Minimal Anxiety

8-15 – Mild Anxiety

16-25 – Moderate Anxiety

26-63 – Severe Anxiety

SAFE Questions

Patient's Name: ______________________________

Physician's Name: Deirdre McMullen M.D. Date: ____________

Do you feel safe in your relationship?

Have you ever been in a relationship where you were threatened, hurt or afraid?

Are your friends or family aware that you have been hurt? Could you tell them, and they would be able to give you support?

Do you have a safe place to go and the resources you need in an emergency?

References: Ashur, ML. Asking about domestic violence: SAFE questions. *JAMA* 1993; 269:2367.

Klemes Female Sexual Function Screener

Patient's Name: ______________________________

Physician's Name: Deirdre McMullen M.D. Date: ______________

INSTRUCTIONS: These questions ask about your present experience. Your responses will be kept completely confidential.

CHECK ONLY ONE BOX PER QUESTION

1. Are you satisfied with your level of sexual desire or interest?
   a. Always
   b. Most times
   c. Sometimes
   d. Never

2. Are you satisfied with your level of lubrication during sexual activity or intercourse?
   a. Always
   b. Most times
   c. Sometimes
   d. Never

3. Are you satisfied with your overall sexual life?
   a. Satisfied
   b. Neutral
   c. Dissatisfied

4. Do you experience discomfort or pain during sexual activity or intercourse?
   a. No
   b. Yes

Scoring:
- a. 0 points
- b. 1 point
- c. 2 points
- d. 3 points

Total:
- 0-3: No action
- 4-10: Assess further