Physical Review Form

Duke Activity Status Index

Patient Name: _____ DOB: _____/_____/_____

The Duke Activity Status Index is a self-administered questionnaire that measures a patient's functional capacity.

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 the 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 or moving heavy furniture?	8.00	0
9	Can you do yard work 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) Max 58.2 Min 0	
Estimated Peak Oxygen Uptake (mL/min) = .43 (Duke Activity Status Index) + 9.6	

THE BURNS DEPRESSION CHECKLIST

Name _____ 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: _____

After you have completed the test, add up your total score. 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	Degree of Depression
0 - 4	Minimal or no depression
5 - 10	Borderline depression
11 - 20	Mild depression
21 - 30	Moderate depression
31 - 45	Severe depression

NUTRITION QUESTIONNAIRE

Questions About Food & Nutrition

1. Who prepares your food?

- ☐ I prepare my own meals
- ☐ Someone cooks for me
- ☐ I go out for most meals

2. Who does the food shopping?

- ☐ I do my own shopping
- ☐ Someone assists me with shopping
- ☐ Someone shops for me

3. How often do you eat the following meals? Mark the appropriate choices.

	Daily	Most of the time	Some of the time	Never
Breakfast				
Lunch				
Dinner				
Snacks				

4. How many servings of vegetables do you eat in a typical day?

- ☐ Four or more
- ☐ Two or three
- ☐ One or more

5. How many servings of fruit do you eat in a typical day? (A serving is usually one small piece or ½ cup canned or cooked)

- ☐ Three or more
- ☐ Two
- ☐ One

6. How often does fish appear on your weekly menu?

- ☐ Two or more times
- ☐ Once
- ☐ Rarely or never

7. When you shop for bread, pasta, rice, cereal, or other grains, how often do you buy the whole-grain versions?

- ☐ Always
- ☐ Sometimes
- ☐ Rarely or never

Nutrition Questionnaire (continued)

8. Which of the following are you most likely to use?

- ☐ Canola or olive oil
- ☐ Corn oil
- ☐ Butter or margarine

9. What kind of milk do you usually drink?

- ☐ Fat-free
- ☐ 1 or 2 percent
- ☐ Whole milk
- ☐ Soymilk
- ☐ None

10. What do you typically drink when thirsty?

- ☐ Water
- ☐ Fruit juice
- ☐ Regular sweetened soda
- ☐ Diet soda
- ☐ Coffee or tea
- ☐ Other _____

11. What is a typical snack?

_____

_____

_____

12. How many servings of the following do you consume each week?

Red meat _____

Eggs _____

Cheese _____

Your Nutrition and Health Concerns

Please tell us what nutrition and health topics are of interest to you.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Physical Review Form

Epworth Sleepiness Index

Patient Name: _____ DOB: ____/____/ _____

The Epworth Sleepiness Index suggests that a patient with a score greater than ten (10) may have excessive sleepiness and require further evaluation.

0 – Never 1 – Slight 2 – Moderate 3 - High

Using the scale above, score the patient's likelihood of dozing when:

Item	Activity	Score
1	Sitting reading	
2	Watching television	
3	Sitting inactive in a public place	
4	Riding as a passenger in a car for one hour	
5	Lying down to rest in the afternoon	
6	Sitting and talking with someone	
7	Sitting quietly after a lunch that did not include alcohol	
8	In a car, stopped for a few minutes in traffic	
9	Driving a moving car	
	TOTAL	

Note: Male patients with a collar size greater than 17 inches, and female patients with a collar size greater than 16 inches, may be at higher risk for sleep apnea.

END OF LIFE PLANNING

What is an Advance Directive?

An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). If you are admitted to the hospital, the hospital staff will probably talk to you about advance directives. A good advance directive describes the kind of treatment you would want depending on how sick you are. For example, the directives would describe what kind of care you want if you have an illness that you are unlikely to recover from, or if you are permanently unconscious. Advance directives usually tell your doctor that you don't want certain kinds of treatments. However, they can also say that you want a certain treatment no matter how ill you are. You should be aware of the laws in your state.

Do you have an Advance Directive? (Check and initial one response below)

☐ Yes _____ Please supply us with a copy to keep on file with your records.

☐ No _____ Please ask your doctor or health care provider for one and return it to be kept on file with your records.

What is a Living Will?

A living will is a specific type of advance directive. It is a written legal document that describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will does not let you select someone to make decisions for you.

Do you have a Living Will? (Check and initial one response below)

☐ Yes _____ Please supply us with a copy to keep on file with your records.

☐ No _____ Please ask your doctor or health care provider for one and return it to be kept on file with your records.

What is a Durable Power of Attorney for Health Care?

A durable power of attorney (DPA) for health care is another kind of advance directive. A DPA states whom you have chosen to make health care decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will. But, a DPA may not be a good choice if you do not have another person you trust to make these decisions for you.

Do you have a Durable Power of Attorney? (Check and initial one response below)

☐ Yes _____ Please supply us with a copy to keep on file with your records.

☐ No _____ Please ask your doctor or health care provider for one and return it to be kept on file with your records.

Signature: _____ Date: _____