Name:______________________________ Date:____________________________________

Review of Systems

In the past 3 months have you had any of the following

1. General Health

Chills	Yes	No
Fatigue	Yes	No
Fever	Yes	No
Night Sweats	Yes	No
Change in appetite	Yes	No
Weight Gain	Yes	No
Weight Loss	Yes	No

2. HEENT

Eye Pain	Yes	No
Blurred Vision	Yes	No
Double Vision	Yes	No
Ear Pain	Yes	No
Trouble Hearing	Yes	No
Ringing in ears	Yes	No
Nasal Congestion	Yes	No
Post Nasal drip	Yes	No
Hoarseness	Yes	No
Sore Throat	Yes	No
Allergies	Yes	No
Hay fever	Yes	No

3. Cardiovascular

Chest Pain	Yes	No
Pain in calf when walking less than 200 yards	Yes	No
Shortness of breath when lying flat	Yes	No
Palpitations	Yes	No
Edema	Yes	No
Rapid heartbeat	Yes	No
Slow heart beat	Yes	No

4. Respiratory

Cough	Yes	No
Shortness of breath	Yes	No
Blood in sputum	Yes	No
Wheezing	Yes	No
Sputum production	Yes	No

5. Gastrointestinal

Abdominal pain	Yes	No
Indigestion	Yes	No
Belching	Yes	No
Difficulty swallowing	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Heartburn	Yes	No
Vomiting Blood	Yes	No
Blood In Stool	Yes	No
Hemorrhoids	Yes	No

Black "tarry" stools	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Change in bowel habits	Yes	No

6.Genitourinary/Nephrology

Burning with urination	Yes	No
Getting up at night to urinate	Yes	No
Frequent Urination	Yes	No
Urinary Urgency	Yes	No
Urinary Incontinence	Yes	No
Blood in Urine	Yes	No

7. Musculoskeletal

Joint Pain	Yes	No
Back Pain	Yes	No
Joint Stiffness	Yes	No
Muscle Pain	Yes	No
Muscle weakness	Yes	No

8. Endocrine

Hair Loss	Yes	No
Excessive Sweating	Yes	No
Hot Flashes	Yes	No
Night Sweats	Yes	No
Increase in Thirst	Yes	No

9. Neurological

Dizziness	Yes	No
Headaches	Yes	No
Memory Loss	Yes	No
Tremor	Yes	No
Vertigo	Yes	No
Numbness	Yes	No
Fainting	Yes	No

10. Hematology

Abnormal bleeding	Yes	No
Easy to bruise	Yes	No
Anemia	Yes	No
Lymph Node enlargements/mass	Yes	No

11. Psychiatric

Anxiety	Yes	No
Depression	Yes	No
Sleep disturbance	Yes	No

12. Skin

Abnormal Moles	Yes	No
Rashes	Yes	No
Abnormal Itching	Yes	No

Females Only

Breast Mass	Yes	No
Nipple Discharge	Yes	No

Date ____ / ____ / 200 ___

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.

Date ____ / ____ / 200 ___

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	

Dr. D. Lahasky

Name______________________________ **Date**______________

Depression Self-Check

1. **Sadness:** Have you been feeling sad or down in the dumps?
   Not at all
   Somewhat
   Moderately
   A lot
2. **Discouragement:** Does the future look hopeless?
   Not at all
   Somewhat
   Moderately
   A lot
3. **Low self-esteem:** Do you feel worthless or think of yourself as a failure?
   Not at all
   Somewhat
   Moderately
   A lot
4. **Inferiority:** Do you feel inadequate or inferior to others?
   Not at all
   Somewhat
   Moderately
   A lot
5. **Guilt:** Do you get self-critical and blame yourself for everything?
   Not at all
   Somewhat
   Moderately
   A lot
6. **Indecisiveness:** Do you have trouble making up your mind about things?
   Not at all
   Somewhat
   Moderately
   A lot
7. **Irritability and frustration:** Have you been feeling resentful and angry a good deal of the time?
   Not at all
   Somewhat
   Moderately
   A lot
8. **Loss of interest in life:** Have you lost interest in your career, your hobbies, your family, or your friends?
   Not at all

Somewhat
Moderately
A lot

9. **Loss of motivation:** Do you feel overwhelmed and have to push yourself hard to do things?
   Not at all
   Somewhat
   Moderately
   A lot
10. **Poor self-image:** Do you tink you're looking old or unattractive?
    Not at all
    Somewhat
    Moderately
    A lot
11. **Appetite changes:** Have you lost your appetite? Or do you overeat or binge compulsively?
    Not at all
    Somewhat
    Moderately
    A lot
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?
    Not at all
    Somewhat
    Moderately
    A lot
13. **Loss of libido:** Have you lost your interest in sex?
    Not at all
    Somewhat
    Moderately
    A lot
14. **Hypochondriasis:** Do you worry a great deal about your health?
    Not at all
    Somewhat
    Moderately
    A lot
15. **Suicidal impulses:** Do you have thoughts that life is not worth living or think that you might be better off dead?
    Not at all
    Somewhat
    Moderately
    A lot

David M. Lahasky, M.D.