James H. Brodsky, MD, PC
4701 Willard Avenue, Suite 224
Chevy Chase, Maryland 20815
T: 301-652-6760 | F: 301-652-6763

Date: ______________________________

Recent Health Information for: ____

Please answer the following questions. If you are unsure, select maybe. Comments are welcomed. Completing this prior to our visit will permit more time to discuss the important issues.

SKIN	Yes	No	Maybe	Comments
Worrisome marks or lumps?	_____	_____	_____	______________
Rash or itching?	_____	_____	_____	______________
Hair or nail changes?	_____	_____	_____	______________
Unusual bruising or bleeding?	_____	_____	_____	______________
EYES				
Visual Changes in the past year?	_____	_____	_____	______________
Do you have glaucoma?	_____	_____	_____	______________
Do you have macular degeneration?	_____	_____	_____	______________
Have you seen your eye doctor in the last 2 years?	_____	_____	_____	______________
EARS/NOSE/THROAT				
Hearing changes in the past year?	_____	_____	_____	______________
Earache or ringing in ears?	_____	_____	_____	______________
Vertigo/dizziness?	_____	_____	_____	______________
Troubling allergy symptoms?	_____	_____	_____	______________
CARDIAC				
Chest pain or tightness?	_____	_____	_____	______________
Palpitation or irregular heartbeat?	_____	_____	_____	______________
Shortness of breath?	_____	_____	_____	______________
Swelling in legs/ankles?	_____	_____	_____	______________
Fainting?	_____	_____	_____	______________
PULMONARY				
Cough, wheeze, or spitting up blood?	_____	_____	_____	______________
Easily out of breath?	_____	_____	_____	______________
Do you smoke?	_____	_____	_____	______________
GASTROINTESTINAL				
Indigestion, nausea, or abdominal discomfort?	_____	_____	_____	______________
Constipation or diarrhea?	_____	_____	_____	______________
Rectal bleeding?	_____	_____	_____	______________
GENITOURINARY (FEMALES ONLY)				
Urine frequency or urgency?	_____	_____	_____	______________
Urine leakage (incontinence)?	_____	_____	_____	______________
Pain or discharge?	_____	_____	_____	______________
Sexual difficulties?	_____	_____	_____	______________
Menstrual problems?	_____	_____	_____	______________

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GENITOURINARY (MALES ONLY)	Yes	No	Maybe	Comments
Pain or discharge?	_____	_____	_____	_______________
Sexual difficulties?	_____	_____	_____	_______________
Please complete separate prostate symptom scoresheet				
MUSCULOSKELETAL				
Troubling joint pain or stiffness?	_____	_____	_____	_______________
Troubling neck or back pain?	_____	_____	_____	_______________
Muscle weakness or pain?	_____	_____	_____	_______________
NEUROLOGIC				
Headaches?	_____	_____	_____	_______________
Numbness or tingling?	_____	_____	_____	_______________
Shaking or tremor?	_____	_____	_____	_______________
Loss of balance?	_____	_____	_____	_______________
PSYCHIATRIC/COGNITION				
Anxiety?	_____	_____	_____	_______________
Depression?	_____	_____	_____	_______________
Change in mood?	_____	_____	_____	_______________
Change in memory?	_____	_____	_____	_______________
Troubling fatigue?	_____	_____	_____	_______________

UPDATE CONTACT INFORMATION

Best telephone to reach you: ____

Best email address: ____

If you are employed, give name of employer and brief job description: ______________________________

____

If you work part-time or retired, what do you do that interests you? ______________________________

____

**Please list the topics you would like to discuss today: ______________________________

____

____

____

____

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Name ______________________________ Date ______________________________

THE EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not 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 (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. theater or meeting)	
As 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	

SCORE RESULTS:

1-6	Congratulations, you are getting enough sleep!
7-8	Your score is average
9 and up	Very sleepy and should seek medical advice

Johns, M.W. (1991). A new method for measuring daytime sleepiness: The Epworth sleepiness scale. Sleep, 14, 540-545. Permission for single-use of the information contained in this material was obtained from the Associated Professional Sleep Societies, LLC, September 2006.

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Name ______________________________ Date ______________________________

DUKE ACTIVITY STATUS INDEX

	Yes	No	Maybe
Can you take care of yourself (eating, dressing, bathing, toileting)?	☐	☐	☐
Can you walk indoors without assistance, such as around your house?	☐	☐	☐
Can you walk a block or two on level ground?	☐	☐	☐
Can you climb a flight of stairs?	☐	☐	☐
Can you run a short distance, say one or two blocks?	☐	☐	☐
Can you do light housework, such as washing dishes or dusting?	☐	☐	☐
Can you do moderate housework, such as vacuuming, sweeping floors, or carrying in the groceries?	☐	☐	☐
Can you do heavy housework, such as scrubbing floors or moving furniture?	☐	☐	☐
Can you do yardwork, such as raking leaves, weeding, or pushing a power mower?	☐	☐	☐
Are you having sexual relations?	☐	☐	☐
Can you participate in moderate recreational activities, such as golf, bowling, double tennis?	☐	☐	☐
Can you participate in strenuous sports, such as swimming, singles tennis, skiing or basketball?	☐	☐	☐

Exercise Routine
Please explain what you do for exercise in an average week: ______________________________

Sleep Routine
Approximately how many hours of sleep do you get? ______________________________

Do you have trouble falling asleep? ______________________________

How many interruptions do you experience? ______________________________

Do you snore? ______________________________

Do you feel refreshed when you wake up? ______________________________

Alcohol Use
How much and what do you drink? ______________________________

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BURNS DEPRESSION CHECKLIST* Instructions: Place a check in the box to the right of each of the 15 symptoms to indicate how much this type of feeling has been bothering you in the past several days.	0- NOT AT ALL	1- SOMEWHAT	2- MODERALTELY	3- ALOT
1. **Sadness:** Have you been feeling sad or down in the dumps?				
2. **Discouragement:** Does the future look bleak or hopeless?				
3. **Low self-esteem:** Do you feel worthless or think of yourself as a loser?				
4. **Inferiority:** Do you feel inadequate or inferior to others?				
5. **Guilt:** Do you get self-critical and blame yourself?				
6. **Indecisiveness:** Is it hard to make decisions?				
7. **Irritability and frustration:** Have you been feeling angry or resentful?				
8. **Loss of interest in life:** Have you lost interest in your career, hobbies, family or 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 compulsively?				
12. **Sleep changes:** Is it hard to get a good night's sleep? Are you tired and sleeping too much?				
13. **Loss of libido:** Have you lost your interest in sex?				
14. **Hypochondriasis:** Do you worry a lot about your health?				
15. **Suicidal impulses:** Do you think life is not worth living or think you'd be better off dead?**				
TOTAL SCORE ON ITEMS 1 – 15				

NAME: ___________________________________ DATE: ____________________________________

*Copyright© 1984 by David D. Burns, M.D. (from *The Feeling Good Handbook*, Plume, 1990).
**Anyone with suicidal urges should seek immediate help from a mental health professional.

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MEN ONLY
IPSS - International Prostate Symptom Score

Name: ______________________ Date: ______________________

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
Urgency Over the past month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
Weak stream Over the past month, how often have you had a weak urinary system?	0	1	2	3	4	5	
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
	None	1 time	2 times	3 times	4 times	5 times or more	Your Score
Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	
TOTAL IPSS Score							

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly Satisfied	Mixed – almost equally satisfied and dissatisfied	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Total score: 0-7 Mildly symptomatic; 8-19 moderately symptomatic; 20-35 severely symptomatic