Patient Name: _____

Patient DOB: _____

BEALES DIAGNOSTIC CRITERIA

PLEASE CHECK ALL THAT APPLY TO YOU:

PRIMARY FEATURES:

☐ Childhood Obesity

☐ Learning Disability

☐ Male Hypogonadism

☐ Kidney Abnormalities

☐ Visual Defects (ie Rod Cone Dystrophy)

☐ Polydactyly (ie extra fingers or toes)

SECONDARY FEATURES:

☐ Diabetes Mellitus

☐ Excessive Thirst, Excessive Urination, or Diagnosis of Nephrogenic Diabetes Insipidus

☐ Strabismus, Cataracts, or Astigmatism

☐ Dental Crowding, Hypodontia, Small Roots, or High Arched Palate

☐ Speech Disorder or Delay

☐ Developmental Delay

☐ Brachydactyly (short fingers or toes) or Syndactyly (webbed toes/feet or fingers/hands)

☐ Ataxia (loss of muscle control), Poor Coordination, or Imbalance

☐ Spasticity

☐ Left Ventricular Hypertrophy, Congenital Heart Disease

☐ Hepatic Fibrosis

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name	**Today's Date**				
Instructions ***Please answer the questions below, rating yourself on a scale of 1 through 5 on each of the criteria as shown to the right. As you answer each question in a way that best describes how you have felt and conducted yourself in the past 6 months. Please give this completed checklist to your healthcare professional to discuss during your appointment.***	1 Never	2 Rarely	3 Sometime	4 Often	5 Always
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐	☐	☐	☐	☐
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐	☐	☐	☐	☐
3. How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐	☐	☐	☐	☐
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?	☐	☐	☐	☐	☐
7. How often do you make careless mistakes when you have to work on a boring or difficult project?	☐	☐	☐	☐	☐
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	☐	☐	☐	☐	☐
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	☐	☐	☐	☐	☐
10. How often do you misplace or have difficulty finding things at home or at work?	☐	☐	☐	☐	☐
11. How often are you distracted by activity or noise around you?	☐	☐	☐	☐	☐
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	☐	☐	☐	☐	☐
13. How often do you feel restless or fidgety?	☐	☐	☐	☐	☐
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?	☐	☐	☐	☐	☐
15. How often do you find yourself talking to much when you are in social situations?	☐	☐	☐	☐	☐
16. When you are in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	☐	☐	☐	☐	☐
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	☐	☐	☐	☐	☐
18. How often do you interrupt others when they are busy?	☐	☐	☐	☐	☐
Total Score: Inattention, Subscale A					
Total Score: Hyperactivity, Subscale B					

General Anxiety Disorder (GAD-7)

NAME DATE

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				
TOTAL SCORE *(add your column scores)*				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, 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?	☐ 0	☐ 1	☐ 2	☐ 3

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)

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	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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
☐	☐	☐	☐

Name _____
Height _____ Weight _____
Age Male / Female _____

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP	Yes	No
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	☐	☐
Do you often feel TIRED, fatigued, or sleepy during daytime?	☐	☐
Has anyone OBSERVED you stop breathing during your sleep?	☐	☐
Do you have or are you being treated for high blood PRESSURE?	☐	☐

BANG	Yes	No
BMI more than 35kg/m2?	☐	☐
AGE over 50 years old?	☐	☐
NECK circumference > 16 inches (40cm)?	☐	☐
GENDER: Male?	☐	☐

TOTAL SCORE

High risk of OSA: Yes 5 - 8

Intermediate risk of OSA: Yes 3 - 4

Low risk of OSA: Yes 0 - 2

Binge Eating Disorder Screener-7 (BEDS-7)

Patient's Name:_____ **Date of Birth**_____

The following questions ask about your eating patterns and behaviours within the last 3 months. For each question, choose the answer that best applies to you.

1. During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)?	YES ☐	NO ☐

NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

2. Do you feel distressed about your episodes of excessive overeating?	YES ☐	NO ☐

Within the past 3 months...	Never or Rarely	Sometimes	Often	Always
3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g. Not being able to stop eating, feel compelled to eat, or going back and forth for more food)?	☐	☐	☐	☐
4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?	☐	☐	☐	☐
5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?	☐	☐	☐	☐
6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?	☐	☐	☐	☐
7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?	☐	☐	☐	☐

Patient Name

Patient Signature

Date:

MEDICATION CONTRADICTIONS

Please circle if you have any of the following:

Heart Disease ☐

Atrial Fibrillation or Abnormal Heart Rhythm ☐

Uncontrolled Hypertension (high blood pressure) ☐

Personal or Family History of Medullary Thyroid Cancer ☐

Personal or Family History of Men II Syndrome ☐

Pancreatitis ☐

Glaucoma ☐

Seizures ☐

Hyperthyroidism ☐

Kidney Stones (calcium oxalate) ☐

Frequent or Regular Use of Pain Medications ☐

Gallstones ☐

Uncontrolled Anxiety or Bipolar Disorder ☐

Use Tobacco Products ☐

Drink more than 2 Alcoholic beverages per day ☐

Illicit Substance Use ☐

Currently Pregnant ☐

Currently Nursing ☐

MAO Inhibitor use within the last 14 days ☐

Tamoxifen use ☐

Digoxin use ☐