11785 Northfall Lane
Suite 505
Alpharetta, GA 30009
Phone: 678-393-0012
Fax: 678-393-5158

NORTHSIDE HOSPITAL

Roswell Internal Medicine Specialists

Patient's name: _____ **DOB:** _____

Instructions: Choose the best answer for how you felt over the past 2 weeks.

1. Are you basically satisfied with your life?	YES / NO
2. Have you dropped many of your activities and interests?	YES / NO
3. Do you feel that your life is empty?	YES / NO
4. Do you often get bored?	YES / NO
5. Are you in good spirits most of the time?	YES / NO
6. Are you afraid that something bad is going to happen to you?	YES / NO
7. Do you feel happy most of the time?	YES / NO
8. Do you often feel helpless?	YES / NO
9. Do you prefer to stay at home, rather than going out and doing new things?	YES / NO
10. Do you feel you have more problems with memory than most?	YES / NO

Patient's signature: _____ **Date:** _____

___ Provider assessment: No further evaluation needed.

___ Referral: _____

Physician's signature: _____ **Date:** _____

Reorder #26686 PP0012 (RIMS_A)
Piedmont Graphics 06/22/17

SCREENING FOR DEPRESSION

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Alpharetta, GA 30009
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NORTHSIDE HOSPITAL

Roswell Internal Medicine Specialists

Patient's name: _____ **DOB:** _____

1. Have you fallen before or been injured because of a fall?	YES / NO
2. Do you feel weaker than you used to or have less strength in your arms and legs?	YES / NO
3. Have you stopped doing daily activities or avoided exercise because you're afraid of falling?	YES / NO
4. Do you experience incontinence?	YES / NO
5. Has your hand strength decreased?	YES / NO
6. Has your eyesight diminished or do you have trouble seeing depth or seeing at night?	YES / NO
7. Do you feel dizzy when you stand up?	YES / NO
8. Have you experienced hearing loss?	YES / NO
9. Do you have foot ulcers, bunions, hammertoes or callouses that hurt or cause you to adjust your steps?	YES / NO
10. Do you feel unsteady on your feet or shuffle when you walk?	YES / NO

Patient's signature: _____ **Date:** _____

___ Provider assessment: No further evaluation needed.

___ Referral: _____

Physician's signature: _____ **Date:** _____

Reorder #26515 PP0011 (RIMS_A)
Piedmont Graphics Rev. 08/22/17

PERSONAL RISK FACTORS FALL PREVENTION CHECKLIST

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Suite 505
Alpharetta, GA 30009
Phone: 678-393-0012
Fax: 678-393-5158

NORTHSIDE HOSPITAL

Roswell Internal Medicine Specialists

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

Things that may be affecting your health:

- ☐ Alcohol
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty with daily activities
- ☐ Drug or Tobacco use
- ☐ Falls or Fall Risk
- ☐ Food Choices
- ☐ Hearing Loss
- ☐ Home Safety
- ☐ Lack of Physical Exercise
- ☐ Medicines
- ☐ Motor Vehicle Safety
- ☐ Pain
- ☐ Weight

Patient signature: _____ Date: _____

Your doctor has referred you for:

Service	Name/Location	Date or N/A
☐ Counseling		
☐ Hearing Specialist		
☐ Nutrition Therapy		
☐ Diabetes Self-Management		
☐ Other		

☐ Please see attached list of Community Resources

Provider signature: _____ Date: _____

Reorder #26508 PP0002 (RIMS_A)
Piedmont Graphics Rev. 08/22/17

RISK FACTORS/REFERRALS/INTERVENTIONS

Original – Chart
Yellow – Patient

ROSWELL INTERNAL MEDICINE SPECIALISTS
Dr. Gorka Zurinaga, M.D.
11785 Northfall Lane, Suites 505 & 506, Alpharetta, GA 30009
p: (678) 393-0012 • f: (678) 393-5158

English - Spanish

PATIENT MEDICAL HISTORY (PART 1)

Full Name (Print): _____

Date of Birth: _____ Today's Date: _____

Please check NO or YES as applicable, if yes, give a brief description of problem.

NO	YES
☐ Weight change	☐
☐ Appetite change	☐
☐ Fever/Chills	☐
☐ Night Sweats	☐
☐ General Weakness	☐
☐ Dizziness, whirling, Or feeling faint	☐

ENDOCRINE SYSTEM

☐ Heat or Cold Intolerance	☐
☐ Thyroid Problems	☐
☐ History of Neck Surgery or irradiation	☐
☐ Increase in Thirst	☐
☐ Increase in Urination	☐

EYES

☐ Failing Vision/ Blind	☐
☐ Cataracts	☐
☐ Double Vision	☐
☐ Pain	☐
☐ Glasses	☐

EAR, NOSE, THROAT

☐ Difficulty Hearing/Deaf	☐
☐ Ringing in Ears	☐
☐ Nose Bleed	☐
☐ Hoarseness	☐
☐ Sinusitis	☐

GASTROINTESTINAL SYSTEM

☐ Nausea	☐
☐ Vomiting	☐
☐ Vomiting Blood	☐
☐ Difficulty in swallowing	☐
☐ Indigestion/ Heartburn	☐
☐ Abdominal Pain	☐
☐ Abdominal Swelling	☐
☐ Jaundice	☐
☐ Red Blood in Stool	☐

NO	YES
☐ Black Stool	☐
☐ Inability to Control Stool	☐
☐ Diarrhea	☐
☐ Constipation	☐
☐ Hemorrhoids	☐
☐ Hernia	☐
☐ Ulcer Disease History	☐
☐ Gall Bladder Disease History	☐
☐ Pancreatitis History	☐

LUNG

☐ Shortness of Breath	☐
☐ Shortness of Breath on Exertion	☐
☐ Sit up to Breathe	☐
☐ Get up after going to sleep To get breath	☐
☐ Cough now? How long?	☐
☐ Phlegm: Volume, Color, Odor, Viscosity	☐
☐ Cough Blood	☐
☐ Wheezing	☐
☐ Blueness in the Lip or Fingertips	☐
☐ Asthma History	☐
☐ Pneumonia History	☐
☐ History of Tuberculosis or Exposure to Tuberculosis	☐
☐ Skilll Test for Tuberculosis Positive ☐ Negative ☐	☐
☐ Chest X-Ray in last year	☐
☐ History of Respiratory Infections, give frequency	☐

HEART & BLOOD VESSELS

☐ Chest Discomfort	☐
☐ Fainting Spells	☐
☐ Palpitations	☐
☐ Swelling of Ankles	☐
☐ Pain in Legs, Calves, or Feet While walking	☐
☐ Swelling or Pain in Calves	☐

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PATIENT MEDICAL HISTORY (PART 1)

PATIENT MEDICAL HISTORY (PART 2)

HEART & BLOOD VESSELS (continued)

NO	YES
☐ Hypertension History	☐
☐ Heart Murmur	☐
☐ Rheumatic Fever	☐

GU SYSTEM (GENERAL)

☐ Frequency passing Urine	☐
☐ Urgency in passing Urine	☐
☐ Pain in passing Urine	☐
☐ Abnormal Urine Color	☐
☐ Blood in Urine	☐

MALE GENITALIA

☐ Stream Size & Force decreased	☐
☐ Hesitancy	☐
☐ Inability to hold Urine (Stress, Urge, Dribbling) of Urine	☐
☐ History of Renal Disease or Stones	☐
☐ History of STD's	☐

FEMALE GENITALIA

☐ Vaginal Bleeding (not Menstrual)	☐
☐ History of STD's	☐

Last Menstrual Period: _____

NERVOUS SYSTEM

NO	YES
☐ Headaches	☐
☐ Loss of Consciousness	☐
☐ Seizures	☐
☐ Stroke History	☐

BLOOD

☐ Abnormal Bleeding / Bruising	☐
☐ Anemia	☐
☐ Transfusions	☐
☐ Family History of Sickle Cell	☐

HEART & BLOOD VESSELS

☐ Joint Stiffness	☐
☐ Joint Pain	☐
☐ Joint Swelling	☐
☐ Muscle Weakness	☐
☐ Backache	☐
☐ NeckPain	☐

PATIENT MEDICAL HISTORY (PART 2)