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

NORTHSIDE HOSPITAL

Roswell Internal Medicine Specialists

(must be viewed by physician, signed and dated)

Patient's name: ______________________________ **Date of Birth:** ______________

Medicare B eligibility date: ____________________ **Today's date:** ______________________

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

1. What is your age? ☐ 65-69 ☐ 70-79 ☐ 80 or older
2. Are you a female or male? ☐ Male ☐ Female
3. During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

   ☐ Not at all
   ☐ Slightly
   ☐ Moderately
   ☐ Quite a bit
   ☐ Extremely
4. During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

   ☐ Not at all
   ☐ Slightly
   ☐ Moderately
   ☐ Quite a bit
   ☐ Extremely
5. During the past four weeks, how much bodily pain have you generally had?

   ☐ No pain
   ☐ Very mild pain
   ☐ Mild pain
   ☐ Moderate pain
   ☐ Severe pain
6. During the past four weeks, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

   ☐ Yes, as much as I wanted
   ☐ Yes, quite a bit
   ☐ Yes, some
   ☐ Yes, a little
   ☐ No, not at all
7. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?

   ☐ Very heavy
   ☐ Heavy
   ☐ Moderate
   ☐ Light
   ☐ Very light
8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?) ☐ Yes ☐ No

HEALTH RISK ASSESSMENT

9. Can you go shopping for groceries or clothes without someone's help? ☐ Yes ☐ No

10. Can you prepare your own meals? ☐ Yes ☐ No

11. Can you do your housework without help? ☐ Yes ☐ No

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around in the house? ☐ Yes ☐ No

13. Can you handle your own money without help? ☐ Yes ☐ No

14. During the past four weeks, how would you rate your health in general?

    ☐ Excellent
    ☐ Very good
    ☐ Good
    ☐ Fair
    ☐ Poor

15. How have things been going for you during the past four weeks?

    ☐ Very well, could hardly be better
    ☐ Pretty well
    ☐ Good and bad parts, about equal
    ☐ Pretty bad
    ☐ Very bad; could hardly be worse

16. Are you having difficulties driving your car?

    ☐ Yes, often
    ☐ Sometimes
    ☐ No
    ☐ Not applicable, I do not use a car

17. Do you always fasten your seat belt when you are in a car?

    ☐ Yes, usually
    ☐ Yes, sometimes
    ☐ No

18. How often during the past four weeks have you been *bothered* by any of the following problems?

    Please indicate with: Never, Seldom, Sometimes, Often or Always

    Falling or *dizzy* when standing up ________________________________
    Sexual problems ________________________________
    Trouble eating well ________________________________
    Teeth or denture problems ________________________________
    Problems using the telephone ________________________________
    Tiredness or fatigue ________________________________

19. Have you fallen two or more times in the past year? ☐ Yes ☐ No

20. Are you afraid of falling? ☐ Yes ☐ No

21. Are you a smoker?

    ☐ No
    ☐ Yes, and I might quit
    ☐ Yes, but I'm not ready to quit

22. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?

    ☐ 10 or more drinks per week
    ☐ 6-9 drinks per week
    ☐ 2-5 drinks per week
    ☐ One drink or less per week
    ☐ No alcohol at all

23. Do you exercise for about 20 minutes three or more days a week?

- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ No, I usually do not exercise this much

24 Have you been given any information to help you with the following:

Hazards in your house that might hurt you? ☐ Yes ☐ No
Keeping track of your medications? ☐ Yes ☐ No

25. How often do you have trouble taking medicines the way you have been told to take them?

- ☐ I do not have to take medicine
- ☐ I always take them as prescribed
- ☐ Sometimes I take them as prescribed
- ☐ I seldom take them as prescribed

26. How confident are you that you can control and manage most of your health problems?

- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ I do not have any health problems

27. What is your race? (Check all that apply)

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Hispanic or Latino origin or descent
- ☐ Other ________________________________

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Provider signature: ______________________________ Date: ____________________

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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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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)
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SCREENING FOR DEPRESSION

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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

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

NO		YES
☐	Heat or Cold Intolerance	☐
☐	Thyroid Problems	☐
☐	History of Neck Surgery or irradiation	☐
☐	Increase in Thirst	☐
☐	Increase in Urination	☐

EYES

NO		YES
☐	Failing Vision/ Blind	☐
☐	Cataracts	☐
☐	Double Vision	☐
☐	Pain	☐
☐	Glasses	☐

EAR, NOSE, THROAT

NO		YES
☐	Difficulty Hearing/Deaf	☐
☐	Ringing in Ears	☐
☐	Nose Bleed	☐
☐	Hoarseness	☐
☐	Sinusitis	☐

GASTROINTESTINAL SYSTEM

NO		YES
☐	Nausea	☐
☐	Vomiting	☐
☐	Vomiting Blood	☐
☐	Difficulty in swallowing	☐
☐	Indigestion/ Heartburn	☐
☐	Abdominal Pain	☐
☐	Abdominal Swelling	☐
☐	Jaundice	☐
☐	Red Blood in Stool	☐
☐	Black Stool	☐
☐	Inability to Control Stool	☐
☐	Diarrhea	☐
☐	Constipation	☐
☐	Hemorrhoids	☐
☐	Hernia	☐
☐	Ulcer Disease History	☐
☐	Gall Bladder Disease History	☐
☐	Pancreatitis History	☐

LUNG

NO		YES
☐	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

NO		YES
☐	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 2)

HEART & BLOOD VESSELS (continued)

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

GU SYSTEM (GENERAL)

NO		YES
☐	Frequency passing Urine	☐
☐	Urgency in passing Urine	☐
☐	Pain in passing Urine	☐
☐	Abnormal Urine Color	☐
☐	Blood in Urine	☐

MALE GENITALIA

NO		YES
☐	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

NO		YES
☐	Vaginal Bleeding (not Menstrual)	☐
☐	History of STD's	☐

Last Menstrual Period: _______________

NERVOUS SYSTEM

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

BLOOD

NO		YES
☐	Abnormal Bleeding / Bruising	☐
☐	Anemia	☐
☐	Transfusions	☐
☐	Family History of Sickle Cell	☐

HEART & BLOOD VESSELS

NO		YES
☐	Joint Stiffness	☐
☐	Joint Pain	☐
☐	Joint Swelling	☐
☐	Muscle Weakness	☐
☐	Backache	☐
☐	NeckPain	☐

PATIENT MEDICAL HISTORY (PART 2)