

NORTHSIDE HOSPITAL

(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 Quite a bit
 Slightly Extremely
 Moderately
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 Quite a bit
 Slightly Extremely
 Moderately
5. During the past four weeks, how much bodily pain have you generally had?
 No pain Moderate pain
 Very mild pain Severe pain
 Mild 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, a little
 Yes, quite a bit No, not at all
 Yes, some
7. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?
 Very heavy Light
 Heavy Very light
 Moderate
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

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 Fair
 Very good Poor
 Good
15. How have things been going for you during the past four weeks?
- Very well, could hardly be better Pretty bad
 Pretty well Very bad; could hardly be worse
 Good and bad parts, about equal
16. Are you having difficulties driving your car?
- Yes, often No
 Sometimes 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 One drink or less per week
 6-9 drinks per week No alcohol at all
 2-5 drinks per week

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: _____

NORTHSIDE HOSPITAL

Patient's name: _____ Date of Birth: _____

Medicare B enrollment date: _____ *

Today's date: _____

Health Risk Assessment has been reviewed by physicians, signed and dated: Initial _____

MEDICAL/SOCIAL HISTORY

Past personal illnesses or injuries:

Injury/Illness/Surgery	Date	Hospitalized? (Indicate Yes or No)

Medications, supplements and vitamins:

Drug allergies/other allergies:

Social history notes (including diet, physical activities, alcohol use, drug use and tobacco use):

Family history notes:

	Mother	Father	Brother	Sister	Son	Daughter
Deceased						
Hypertension						
Stroke						
Diabetes						
Kidney disease						
Heart disease						
Cancer						

Other physicians and providers/suppliers of care (include provide name, specialty & type of care)

DEPRESSION SCREEN*

- 1. Over the past 2 weeks, have you felt down, depressed or hopeless?
- 2. Over the past 2 weeks, have you felt little interest/pleasure in doing things?

Yes No
 Yes No

TO BE COMPLETED WITH THE PROVIDER

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____ BMI: _____

Visual Acuity:

	With Correction	Without correction
L		
R		
Both		

FUNCTIONAL ABILITY/SAFETY SCREEN*

- 1. Was the patient's timed Up & Go test unsteady or long than 30 seconds?
- 2. Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money?
- 3. Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting?
- 4. Have you noticed any hearing difficulties?

Yes No
 Yes No
 Yes No
 Yes No

*A "yes" answer to any of the questions regarding depression or function/safety should trigger further evaluation, screenings or referrals.

(Use additional screening questionnaires)

EVALUATION OF COGNITIVE FUNCTION

Mood/Affect: _____

Appearance: _____

Family member/Caregiver input: _____

ELECTROCARDIOGRAM (G0403-EKG) – Only at the time of the IPPE

Referral or result: _____

EVALUATIONS/REFERRALS BASED ON HISTORY, EXAM AND SCREENING:

DISCUSSION OF ADVANCE DIRECTIVE

(PATIENT PREFERENCE, PHYSICIAN AGREEMENT/DISAGREEMENT-if patient consents):

List of Community Resources was given to patient

Physicians signature: _____ Date: _____

NORTHSIDE HOSPITAL

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:** _____

NORTHSIDE HOSPITAL

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Today's date: _____

Service	Recommendation
Vaccinations	Date or N/A
Influenza (every 12 months)	
Pneumococcal (once in a lifetime)	
Hepatitis B	

Labs	Date or N/A
PSA-males (every 12 months)	
Cardiovascular screening - Lipid panel (every 5 years)	
Diabetes screening-FBS or GTT*	
*2 screening tests per year if diagnosed with pre-diabetes; 1 test per year if never tested OR tested previously but not diagnosed with pre-diabetes	

Women's Services	Date or N/A
Mammography screening (Age 40 and over - annually)	
Pap smear 9 (every 24 months or yearly if high risk)	
Pelvic exam (every 24 months or yearly if high risk)	

Diagnostic Services	Date or N/A
Bone mass measurement - DEXA (every 24 months)	
Glaucoma screening by an Optometrist (annually)	
Digital Rectal Exam - males (annually)	
Colorectal cancer screening (age 50 and over)*	
*FOBT (every 12 months)	
*Flex Sig (every 4 years or 120 months after screening colonoscopy for non-high risk)	
*Colonoscopy screening (every 10 years or 24 months for high risk)	
*Barium enema - as an alternative to Flex Sig (every 48 months or 24 months for high risk)	

Additional Recommendations
Diabetes self-management training
Medical nutrition therapy services
Abdominal aortic aneurysm screening - MUST be referred through IPPE (once in a lifetime)

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

For an all inclusive list see: "Medicare Preventative Services Quick Reference."

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Things that may be affecting your health:

- | | |
|---|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Home Safety |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lack of Physical Exercise |
| <input type="checkbox"/> Difficulty with daily activities | <input type="checkbox"/> Medicines |
| <input type="checkbox"/> Drug or Tobacco use | <input type="checkbox"/> Motor Vehicle Safety |
| <input type="checkbox"/> Falls or Fall Risk | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Food Choices | <input type="checkbox"/> Weight |

Patient signature: _____ **Date:** _____

Your doctor has referred you for:

Service	Name/Location	Date or N/A
<input type="checkbox"/> Counseling		
<input type="checkbox"/> Hearing Specialist		
<input type="checkbox"/> Nutrition Therapy		
<input type="checkbox"/> Diabetes Self-Management		
<input type="checkbox"/> Other		

Please see attached list of Community Resources

Provider signature: _____ **Date:** _____

NORTHSIDE HOSPITAL

Northside Hospital offers a full range of outpatient services.

Health Screenings: At Northside, our goal is to help you live healthier lives and prevent disease. Throughout the year, we offer health screenings at a variety of convenient locations throughout the communities we serve. Some screenings may be free or at low cost to those who qualify. For more information please visit <http://www.northside.com/healthscreenings>

Nutrition Services: Weight management and nutrition services designed to help you achieve optimal health and feel your best. For more information please call 404-236-8036.

Smoking Cessation: As part of our comprehensive approach to prevention and early detection, Northside offers a Smoking Cessation Program to help individuals quit smoking. For more information please call 404-780-7653 or email smokingcessation@northside.com.

Diabetes Education: Northside's outpatient diabetes education program is recommended for newly diagnosed patients as well as those whose diabetes control needs improvement. The program is available on an individual basis or in small group settings at each Northside campus. For more information please call:

- **Atlanta**
404-851-6023

- **Alpharetta**
404-851-6023

- **Cumming**
404-851-6023

- **Woodstock**
678-388-6400

Community Resources-Tri Campus

Agency on Aging: The Georgia area local Agency on Aging can help you find information about transportation services, Meals on Wheels, classes on healthy living and more.

- **Region 2 Counties:** Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union and White
Phone: 770-538-2650 Web: www.legacylink.org
- **Region 3 Counties:** Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Fulton, Gwinnett, Henry and Rockdale
Phone: 404-345-2675 Web: www.agewiseconnection.com

Georgia Department of Public Health: The Georgia Department of Public Health (DPH) is the lead agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a health perspective.

Phone: 404-657-2700 Web: <https://dph.georgia.gov/>

United Way: Offers assistance in areas of health, education and many more.

- Greater Atlanta & Cherokee: 404-527-7200 Web: www.unitedwayatlanta.org
- Forsyth: 770-781-4110 Web: www.unitedwayforsyth.com

Tobacco quit line of Georgia: 1-877-270-STOP

YMCA: Offers physical activities, self-management programs and more at many YMCA locations.
Web: <http://www.ymcaatlanta.org/programs-for-adults/>

Metro Atlanta:

- Cowart Family/Ashford Dunwoody
Phone: 770-451-9622 Web: www.cay.ymcaatlanta.org
- Ed Isakson Alpharetta Family YMCA
Phone: 770-664-1220 Web: www.iay.ymcaatlanta.org

Cherokee County:

- G. Cecil Pruett Community Center Family YMCA
Phone: 770-345-9622
- Cherokee Outdoor YMCA
Phone: 770-345-9622

Forsyth County:

- Forsyth County Gymnasium
Phone: 770-888-2788 Web: <http://www.ymcaatlanta.org/ymca-locations/cumming/>
- Ed Isakson Alpharetta Family YMCA
Phone: 770-664-1220 Web: www.iay.ymcaatlanta.org