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
   ☐ 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
☐ Sometimes I take them as prescribed
☐ I always 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
☐ Not very confident
☐ Somewhat 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)

WELCOME TO MEDICARE
IPPE/ANNUAL WELLNESS VISIT

DEPRESSION SCREEN*

1. Over the past 2 weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ No
2. Over the past 2 weeks, have you felt little interest/pleasure in doing things? ☐ 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? ☐ Yes ☐ No
2. Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? ☐ Yes ☐ No
3. Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting? ☐ Yes ☐ No
4. Have you noticed any hearing difficulties? ☐ 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:** _____

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SCREENING FOR DEPRESSION

Northside Hospital

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:** _____

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PERSONAL RISK FACTORS FALL PREVENTION CHECKLIST

NORTHSIDE HOSPITAL

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

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 of 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."

Reorder #26513 PP0008
Piedmont Graphics 02/19/16

COUNSELING AND/OR REFERRAL OF PREVENTATIVE SERVICES

Original – Chart
Yellow – Patient

NORTHSIDE HOSPITAL

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: _____

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