SANDY SPRINGS SSIM INTERNAL MEDICINE

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HISTORY AND PHYSICAL PREPARATION INSTRUCTIONS

Please follow the instructions below in preparation for your History and Physical Examination. Some of the questions may seem unnecessary or repetitive, but it is important for the full assessment of your health status every year. Thank you for your cooperation!

- ✓ Fill out the Questionnaire a day or more in advance and bring it with you on your appointment date. **Please complete front and back of each page.**
- ✓ Please have nothing to eat or drink other than water, black coffee or unsweetened tea for twelve (12) hours prior to your appointment. **Drink PLENTY of water the morning of your exam to prevent dehydration.**
- ✓ Please take your usual medications, including blood pressure medications, with water on the day of. **Diabetic patients should *NOT* take their diabetes pills or insulin shots on the morning of the exam.**
- ✓ Please do not apply any oils or lotions to your skin prior to appointment unless absolutely necessary. The EKG (electrocardiogram) leads will not adhere to your skin.

Have you heard of about our new patient portal? This secure online web account provides you private and secure access to your personal health record including medications, lab results, immunization history, and more. You can also request refills for current medications and request appointments directly. We are happy to be able to offer this service to you as an additional benefit of your membership in our practice. We encourage you to create your account, login, and become familiar with the new services now available. ***Ask us for your invitation today!***

If you have any questions, please call us at «USTele» or visit us online at

www.ssim.com

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MALE REVIEW OF SYSTEMS

Please check any symptoms that you have experienced in the past year
Check this box and go to next page if ALL systems are negative **[ ]**

GENERAL
[ ] Appetite Loss
[ ] Fatigue
[ ] Night Sweats
[ ] Weight Gain past year (amount_____lbs)
[ ] Weight Loss past year (amount_____lbs)
[ ] Failure to get regular exercise

SKIN
[ ] Change in Wart/Mole
[ ] Itching
[ ] Rash
[ ] New skin lesion

HEENT
[ ] Double Vision
[ ] Glaucoma
[ ] Visual Disturbances
[ ] Hearing Loss
[ ] Ringing in the Ears
[ ] Nosebleeds
[ ] Nasal congestion
[ ] Hoarseness
[ ] Problems with teeth

NECK
[ ] Neck Pain
[ ] Neck Stiffness
[ ] Neck Swelling

RESPIRATORY
[ ] Snoring
[ ] Persistent Cough
[ ] Coughed up Blood in Past Year
[ ] Shortness of Breath
[ ] Tobacco user
[ ] Former smoker

BREAST
[ ] Breast Mass
[ ] Nipple Discharge

CARDIOVASCULAR
[ ] Edema/Swelling
[ ] Elevated Blood Pressure
[ ] Fainting or near-fainting
[ ] Chest pain/Tightness in Shoulders/Neck/Arms
[ ] Heart pounding/Fluttering (Palpitations)

GASTROINTESTINAL
[ ] Abdominal Pain
[ ] Frequent or Persistent Bloating
[ ] Change in Bowel Habits
[ ] Constipation
[ ] Difficulty Swallowing
[ ] Hemorrhoids
[ ] Heartburn
[ ] Loose Stools
[ ] Rectal Bleeding
[ ] History of Colon Polyps

MALE GENITOURINARY
[ ] Blood in Urine
[ ] Slow Urine Stream
[ ] Difficulty with erections
[ ] Trouble Starting to Urinate/Hesitancy
[ ] Urinate > 1x/night (Nocturia)
[ ] Kidney stone(s)
[ ] Prostate Trouble
[ ] Lump in Testicle

MUSCULOSKELETAL
[ ] Back Pain
[ ] Joint Pain/stiffness
[ ] Joint Swelling

NEUROLOGICAL
[ ] Decreased Memory
[ ] Dizziness
[ ] Headaches
[ ] Numbness
[ ] Tremor
[ ] Unsteadiness/falls

PSYCHIATRIC
[ ] Anxiety
[ ] Insomnia
[ ] Suicidal Thoughts
[ ] Do you usually feel Unhappy/Depressed?
[ ] Relatives with Manic Depressive/Bipolar Disorder
[ ] Previous psychological counseling

HEMATOLOGY
[ ] Anemia
[ ] Blood Clots
[ ] Enlarged Lymph Nodes

Please List Health Problems or Symptoms You Would Like to Discuss at this Visit

Provide Names of Other Physicians Involved in your Medical Care

Name	Specialty

Please provide dates of your most recent:

	Date
Tetanus vaccine	
Pneumococcal vaccine	
Influenza vaccine	
Shingles vaccine	
Blood transfusion	
Blood donation	

	Date
Other vaccines	
Bone Density	
Eye exam	
Colonoscopy	

List Prescription Medications You Are Presently Taking

Prescription Medications	Dosage and Frequency

List Non-prescription Medications and Supplements You Are Presently Taking

Non-Rx Meds, Vitamins, and Supplements	Dosage and Frequency

List Allergies and Type of Reaction

List Your Preferred Pharmacies (Name, Address, and Phone Number)

Local Pharmacy:			
Mail Order:			

Personal Habits

Alcohol-containing drinks **per week**

Wine _____ Beer _____ "Hard liquor" _____

Smoking History (Circle One)

Current Smoker (cigarettes/day_____) Never Smoker Former Smoker (Quit Date_____)

Exercise

Describe your type of exercise_____

How many minutes per week? _____ How many days per week? _____

Dietary Habits — Check the Applicable Entry

Unchanged since previous exam [ ]	Seldom/never	Occasionally	Frequently
Fresh or Frozen Vegetables			
Sweetened drinks			
Whole grain foods			
Desserts			
Fish or Skinless Poultry			
Whole Milk/Cheese Dairy Products			
Nuts (e.g. walnuts, almonds)			
Fried foods			
Olive oil			
Added Salt			
Red Meat (Beef and Pork)			
Processed Meats (e.g., sausage, hot dogs, salami)			
Candy and Sweet Snacks			
Restaurants and "Fast Food"			
Low fat dairy (1% or Non-fat)			

Sleep Habits

I go to bed at _____:_____ pm

I judge my quality of sleep as GOOD FAIR POOR

I generally get out of bed for the day at _____:_____ am

Fall Risk Assessment

If ALL questions in this group are "No" check here [ ]

Falls are a serious health concerns related to many diseases, medical conditions, or medications. This questionnaire is to assess your risk so that we may take proactive preventive precautions if possible. Please check each of the following as it applies to you.

Yes	No	
		Are you 65 years or older?
		Have you fallen within the past 3 months?
		Are you unsteady on your feet or do you have general weakness?
		Are you taking any medications that cause fatigue or dizziness?
		Have you had a stroke in the past?
		Do you have a progressive neurological disorder?
		Do you have diabetes?
		Do you have neuropathy, arthritis, or joint disease of the lower extremities?
		Do you have any visual disturbances?
		Do you feel that you have declining agility?
		Do you have a fear of falling?
		Do you have painful feet?
		Do you have to rush to get to the bathroom in time?

Elder Abuse Suspicion Index (EASI)	**Yes**	**No**	**Did not answer**
Have you relied on people for any of the following: Bathing, dressing, shopping, banking, or meals?			
Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with someone you wanted to be with?			
Have you been upset because someone talked to you in a way that made you feel shamed or threatened?			
Has anyone tried to force you to sign papers or to use your money against your will?			
Has anyone made you afraid, touched you in ways you did not want, or hurt you physically?			

Mental Health History

If ALL questions in this group are "0-Never" check here [ ]

Instructions: The following is a list of symptoms that people frequently have. Put a check in the space to the right that best describes how much of that symptom or problem has bothered you during the past week.	0 – Never	1 - Somewhat	2 - Moderately	3 - A lot
1. Sadness: Have you been feeling sad or down in the dumps?				
2. Discouragement: Does the future look hopeless?				
3. Low self-esteem: Do you feel worthless or think of yourself as a failure?				
4. Inferiority: Do you feel inadequate or inferior to others?				
5. Guilt: Do you get self-critical and blame yourself for everything?				
6. Indecisiveness: Do you have trouble making up your mind about things?				
7. Irritability and frustration: Have you been feeling resentful and angry a good deal of the time?				
8. Loss of interest in life: Have you lost interest in your career, your hobbies, your family, or your friends?				
9. Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?				
10. Poor self-image: Do you feel that you are looking old or unattractive?				
11. Appetite changes: Have you lost your appetite, or do you overeat or binge compulsively?				
12. Sleep changes: Do you suffer from insomnia and find it hard to get a good night's sleep?				
13. Loss of libido: Have you lost your interest in sex?				
14. Hypochondriasis: Do you worry a great deal about your health?				
15. Suicidal impulses: Do you have thoughts that life is not worth living or do you think that you might be better off dead?				

Safe–Domestic Violence Questionnaire

Please check the appropriate box corresponding to each line	Yes	No	N/A
1. Do you feel safe in your relationship?			
2. Have you ever been in a relationship where you were threatened, hurt, or afraid?			
3. Are your friends and family aware that you have been hurt?			
4. Do you have a safe place to go to and the resources you need in an emergency?			

Mood Disorder Questionnaire

If ALL questions in this group are "No" check here [ ]

1. Has there ever been a period of time when you were not your usual self and…		Yes	No
	…you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?		
	…you were so irritable that you shouted at people or started fights or arguments?		
	…you felt much more self-confident than usual?		
	…you got much less sleep than usual and found that you didn't really miss it?		
	…you were more talkative or spoke much faster than usual?		
	…your thoughts raced through your head and you could not slow your mind down?		
	…you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
	…you had much more energy than usual?		
	…you were much more active or did many more things than usual?		
	…you were much more social or outgoing than usual, e.g., you telephoned friends in the middle of the night?		
	…you were much more interested in sex than usual?		
	…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
	…you spent money that got you or your family into trouble?		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time question			

3. How much of a problem did any of these cause you?	No problem	Minor problem	Moderate problem	Serious problem
4. Have any of your blood relatives had manic depressive illness or bipolar disorder?				
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?				

Beck Anxiety Inventory

If ALL questions in this group are "Not at All" check here [ ]

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by this symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

Symptom	Not at All	Mildly	Moderately	Severely
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in the legs	0	1	2	3
Inability to relax	0	1	2	3
Fear of the worst happening	0	1	2	3
Dizziness or lightheadedness	0	1	2	3
Heart pounding or racing	0	1	2	3
Unsteadiness	0	1	2	3
Terror or fear	0	1	2	3
Nervousness	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shakiness/unsteadiness	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty with breathing	0	1	2	3
Fear of dying	0	1	2	3
Fear of the unknown	0	1	2	3
Unexplained abdominal or chest pain	0	1	2	3
Near fainting	0	1	2	3
Flushing	0	1	2	3
Cold sweats	0	1	2	3
TOTAL EACH COLUMN				

Column summation: Add the total of each column to determine a total score: _____

Interpretation

0-21: Very low anxiety 22-35: Moderate anxiety Greater than 35: Severe anxiety

Epworth Sleepiness Index

If ALL questions in this group are "Never" check here [ ]

Please indicate your likelihood of DOZING while engaged in the following activities:

Activity Check the Applicable Box in Each Row	**Never**	**Slight**	**Moderate**	**High**
	0	**1**	**2**	**3**
Sitting Reading				
Watching Television				
Sitting Inactive in a Public Place				
Riding as a Passenger in a Car for One Hour				
Lying Down to Rest in the Afternoon				
Sitting and Talking with Someone				
Sitting Quietly After Lunch				
In a Car, Stopped for a Few Minutes in Traffic				
Driving a Moving Car				
TOTALS				
GRAND TOTAL				

End of life planning

An advanced directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions yourself. It describes the kind of treatment you would want depending on how sick you are and depending on how likely or unlikely you are to recover from a severe disabling condition.
Do you have an advanced directive? (Please check and initial one response below)

Yes		Please supply us with a copy of your completed directive to keep on file with your records
No		Please ask your doctor for a form to complete and return to us for your health records

CAGE Assessment of Alcohol Use:

Have you ever felt you should cut down on your drinking?	Yes	No
Have people annoyed you by criticizing your drinking?	Yes	No
Have you ever felt bad or guilty about your drinking?	Yes	No
Have you ever had morning drink to steady you nerves or get rid of a hangover?	Yes	No

AUASS (American Urological Society Symptom Score) & Quality of Life

Males Only

Score the following questions below using these values:

Not at all	Less than 1 in 5	Less than half the time	About one half the time	Greater than half the time	Almost all the time
0	1	2	3	4	5

*_____Over the past month or so, how often have you had a sensation of not emptying your bladder completely after finishing urinating?

*_____During the past month or so, how often have you had to urinate again less than 2 hours after he finished urinating?

*_____During the past month or so, how often have you found you stopped and started again several times while urinating?

*_____During the past month or so, how often have you found it difficult to postpone urination?

*_____During the past month or so, how often have you had a weak urinary stream?

*_____During the past month or so, how often have you had to push or strain to begin urination?

*_____During the past month, how many times per night did you most typically get up to urinate from the time he went to bed at night until the time you got up in the morning?

*_____**TOTAL AUASS SCORE**

Quality of Life Score

How would do feel if you had to live with your urinary condition the way it is now, no better or worse, for the rest of your life?

Please circle the applicable number

TOTALLY SATISFIED TOTALLY UNSATISFIED

0	1	2	3	4	5	6

Family History

Unchanged since Prior Exam [ ]

Disorder	Relationship
Diabetes	
Heart disease	
Hypertension	
Stroke	
Seizure disorder	
Hay fever or asthma	
Migraines	
Cancer (Type of cancer:)	
Other cancer (Type of cancer:)	
Thyroid disease	
Severe arthritis	
Gallbladder disease	
Kidney disease/disorder	
Hearing loss	
Bleeding or clotting disorder	
Other inherited disorder	
Other	

	Age	State of health if living	Age at death	Cause of death if deceased
Mother				
Father				
Brothers				
Sisters				
Spouse				
Children				

Past Medical History

Unchanged since Prior Exam [ ]

ILLNESS	YES	SUSPECTED	NO	AGE
Hepatitis				
Nephritis				
Tuberculosis				
Pneumonia				
Asthma or Hay Fever				
Rheumatic Fever				
Sexually-transmitted disease				
Cancer (please specify site-)				
Coronary Heart Disease				
Hypertension				
Phlebitis/Blood Clots				
Gall Bladder Disease				
Anemia				
Rheumatoid Arthritis				
Diabetes				
Thyroid Disease				
Hives				
Seizure Disorder				

List any other serious conditions for which you required treatment:

Past Surgical Procedures

Surgical procedure	Age
Appendectomy	
Gallbladder	
Tonsillectomy	
Hysterectomy	
Hernia Repair	

Other surgical procedures or serious injuries: