PATIENT NAME: **DOB:**

2020 Annual Wellness Form

The following information is being collected today as part of an Annual Wellness Visit. We understand that some of this information may have already been communicated to the doctor, but we would like to ensure that we keep your medical records up to date. If you have any questions, please let us know.

Patient Name	Date of Birth	Physician Name	Today's Date

MEDICAL AND SURGICAL HISTORY

ALLERGIES

MEDICATIONS

List all medications including OTCs, vitamins/minerals, and dietary supplements including dosage, frequency, and route of administration

FAMILY HISTORY

	Father	Mother	Children	Sibling	Grandparents
Hypertension	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐

GENERAL HEALTH & HEALTH MANAGEMENT

In general, would you say your health is:	☐Excellent ☐Very Good ☐Good ☐Fair/Poor
In general, would you say your hearing is:	☐Excellent ☐Very Good ☐Good ☐Fair/Poor
Please describe the current condition of your mouth and teeth (including false teeth or dentures)?	☐Excellent ☐Very Good ☐Good ☐Fair/Poor
In the past 7 days, how much pain have you felt?	☐ None ☐Some ☐A lot
How confident are you that you can control and manage most of your health problems?	☐I do not have any health problems ☐Confident ☐Somewhat confident ☐Not Very Confident
Current physical activity as compared to last year is?	☐More ☐ Less ☐Same

PATIENT NAME: **DOB:**

VACCINATION & IMMUNIZATIONS

Did you receive **last season's (Aug. 1, 2018-March 31, 2019)** Flu immunization?	☐ Yes ☐ No ☐ Declined ☐ Allergic _____/_____/_____ Month Day Year
Have you received **this season's (Aug. 1, 2019-March 31, 2020)** Flu immunization?	☐ Yes ☐ No ☐ Declined ☐ Allergic _____/____/_____ Month Day Year
When was your last Tetanus shot?	☐ Yes ☐ No ☐ Declined ☐ Allergic _____/_____/_____ Month Day Year
Have you ever had a Shingles Vaccination?	☐ Yes ☐ No ☐ Declined
Have you ever had a Pneumonia Vaccination?	☐ Prevnar 13_____/_____/_____ ☐ Pneumovax 23_____/_____/_____ ☐ Yes, but I'm not sure of the type_____/_____/_____ ☐ No

DIAGNOSTIC HISTORY

Please complete the following section with as much information as possible. Leave a section blank, if the section does not apply to you or if you do not remember the information.

Colonoscopy	_____/_____/_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal ☐ Other Results ☐ Not Applicable due to total Colectomy or colorectal cancer
Diabetic Eye Exam	_____/_____/_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Diabetic HbA1c	_____/_____/_____ Month / Day / Year	_____ HbA1c Level	
Eye Exam	_____/_____/_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Echocardiogram	_____/_____/_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Dental Exam	_____/_____/_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Bone Density	_____/_____/_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Hepatitis C	_____/_____/_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Prostate Exam	_____/_____/_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
FEMALES ONLY			
Last Mammogram	_____/_____/_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results ☐ Not Applicable due to Bilateral mastectomy or 2 unilateral mastectomies
Pap Smear	_____/_____/_____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results

PATIENT NAME: **DOB:**

ADULT DEPRESSION SCREENING TOOL- PHQ-9 (*If under the age of 18, please request an Adolescent screening tool)*

In the Past 2 weeks:	Not at All	1 – 3 Days	Half the Days	Everyday
I have little interest or pleasure in doing things	0	1	2	3
I'm feeling down, depressed, or hopeless	0	1	2	3
I'm having trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
I'm feeling tired or have little energy	0	1	2	3
I haven't had an appetite or am overeating	0	1	2	3
I'm feeling bad about myself, I feel I've let my family or myself down	0	1	2	3
I have trouble concentrating on things such as reading the paper or watching TV	0	1	2	3
People have noticed that my speech slowed down or is rushed like I am restless	0	1	2	3
I have thoughts I would be better off dead or have thought about hurting myself in someway	0	1	2	3
(OFFICE USE ONLY) **TOTALS**	=	+	+	+

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people.	Not at All ☐	Somewhat Difficult ☐	Very Difficult ☐	Extremely Difficult ☐

TOBACCO / ALCOHOL/ OTHER ASSESSMENT

Do you currently use any form of tobacco products?	☐ Yes ☐ No
If yes, how many years have you used tobacco products?	_____years
What form of tobacco do you use?	☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe ☐E-Cig
If you do smoke, would you like to quit?	☐ Yes ☐ No
Do you drink alcoholic beverages?	☐ Yes ☐ No
How many per week?	☐ 10 or more ☐ 6-9 per week ☐ 2-5 per week ☐ I do not drink alcohol
Do you drink caffeine?	☐ Yes ☐ No # servings a day _____
Do you use sunscreen?	☐ Yes ☐ No
Do you use recreational drugs?	☐ Yes ☐ No

FALL RISK ASSESSMENT

During the last 12 months, have you fallen 2 or more times?	☐Yes ☐No
During the last 12 months, have you had a fall that resulted in an injury?	☐Yes ☐No
Do you think that you are at high risk for falling?	☐Yes ☐No
Do you use any assistive devices such as a walker, wheelchair or cane?	☐Yes ☐No
Are you having trouble with walking or balance?	☐Yes ☐No
Do you require assistance getting up from a sitting position?	☐Yes ☐No

PAIN ASSESSMENT

Are you experiencing any pain?
Please rate your pain on a scale of 0-10: _____ Pain Level (1-10)

Location and description of pain : _____
_____

PATIENT NAME: **DOB:**

IVD AND STATIN

Are you taking ANY of the following medications Prasugrel (Effient), Aspirin, Clopidogrel (Plavix), Ticlopidine (Ticlid), Dipyridamole (Persantine), Ticagrelor (Brillinta)?	☐Yes ☐No
Are you taking a Statin?	☐Yes ☐No

ACTIVITIES OF DAILY LIVING

During the past 4 weeks, was someone available to help you if you needed and wanted help?	☐ No, Not at all ☐ Yes, Sometimes ☐ Yes, Always

In the past 4 weeks, have you had any trouble doing any of the following? If applicable, please list an individual who helped complete the task.

Take medications	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Getting around the home	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Bathing and Dressing	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Using the Telephone	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Traveling	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Grocery Shopping	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Preparing Meals	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Housework	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Managing Money	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Do you have a living will?	☐Yes ☐No
Do you have difficulty driving your car?	☐ No, difficulty ☐ Yes, sometimes ☐ No, I do not drive
Do you always fasten your seat belt when in a vehicle?	☐ Yes ☐ No
During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?	☐Heavy ☐Moderate ☐Light ☐Very Light
Do you exercise for 20 minutes, 3 or more days a week?	☐Yes, most of the time ☐Yes, some of the time ☐No, I do not exercise
Have you been given information to help you with the following: • Hazards in the home which may hurt you? • Keeping track of your medications?	 ☐ Yes ☐ No ☐ Yes ☐ No

Please indicate any of the following Chronic Conditions that apply to you:

Chronic Condition	Date diagnosed	Managing Doctor	Date you last saw doctor	Today Physician Initials
Chronic Kidney Disease				
Cancer				
Coronary Artery Disease				
Depression/Anxiety				
Diabetes, (Type 1 or 2)				
DVT				
Genetic Disorder				
Heart Disease				
High Blood Pressure				
Liver Disease				
Osteoporosis				
Paraplegic/Quadriplegic				
Neurological Disorder				
Stroke				
Rheumatoid Arthritis				

PATIENT NAME: **DOB:**

LIST OF PHYSICIANS
Optometrist
OB/GYN
Ophthalmologist
Cardiologist
Gastroenterologist
Nephrologist
Oncologist
Orthopedist
Pulmonologist
Rheumatologist
Urologist
Neurologist
Psychiatrist
Home Health Company
CPAP Company
Diabetes Supply Company
Other Supply Companies
Other
Other

PATIENT NAME: **DOB:**

Physician Review

The following Information is being collected as part of the patient wellness exam. Please start by reviewing the Patient Questionnaire, with the special focus on the Depression Screening and Fall Risk screening which may require a follow-up visit.

TYPE OF AWV
☐ Initial AWV ***G0438***
☐ Subsequent AWV ***G0439***
☐ Welcome to Med ***G0402***

Patient Name _____ Date of Birth _____

BMI

Height _____ Weight _____ BMI Score _____

If BMI is ABOVE or BELOW normal, please create a BMI follow-up plan. Space is provided below

_____

_____

_____

AGES 18 years and older
☐ NORMAL (BMI between 18.5 to 24.9) ***G8420***
☐ ABOVE NORMAL (BMI > or = 25) ***G8417***
☐ **Morbid Obesity (BMI <40 Or <35 w/comorbidities)** ***E66.01***
☐ BELOW NORMAL (BMI <18.5) ***G8418***
☐ **BELOW NORMAL (BMI <18.5)** ***E46***

☐ ***NOT ELIGIBLE*** *- Documentation of medical or patient reason(s) for no BMI (i.e pregnancy, patient refusal of height and/or weight)* ***G8422***

CONTROLLING HIGH BLOOD PRESSURE

Select One

Does the patient have an active diagnosis or history of hypertension? ☐ Yes ☐ No

☐ **Chronic diastolic Congestive Heart Failure I50.32**
☐ **Acute on Chronic Diastolic Congestive Heart Failure I50.33**
☐ **Unspecified combined systolic and diastolic Congestive Heart Failure I50.40**
☐ **Other (I50._ _)**

_____ / _____
Systolic Diastolic

☐ Controlled (Systolic BP<140mm/Hg) ***G8752***
☐ Uncontrolled (Systolic BP >=140mm/Hg) ***G8753***

☐ Controlled (Diastolic BP<90mm/Hg) ***G8754***
☐ Uncontrolled (Diastolic BP>=90mm/Hg) ***G8755***
☐ ***NOT ELIGIBLE*** *- Documentation of end stage renal disease (ESRD), dialysis, renal transplant or pregnancy* ***G9231***
OR *Patient is 65 and older in Special Needs Plans or residing in Long-Term Care*

VACCINATION & IMMUNIZATIONS

*See Patient Questionnaire for more information **(Page 2)**

Has patient received a Flu Immunization for the 2019-2020 Flu Season? (Aug. 1 2019 – March 31, 2020)

_____/_____/_____
Month / Day / Year

☐ Administered or previously received **G8482**
NOT ELIGIBLE *- Influenza Immunization was not administered for reasons documented by clinician:*
☐ ***Medical:*** *patient allergy or other medical reasons* ***G8483***
☐ ***Patient:*** *Patient declined or other patient reasons* ***G8483***
☐ ***System:*** *Vaccine not available or other system reasons* ***G8483***
☐ Not administered

Has patient ever received a Pneumonia Vaccination?

☐ Prevnar 13_____/_____/_____
☐ Pneumovax 23_____/_____/_____
☐ No

☐ Administered or previously received **4040F**
☐ Patient Declined

PATIENT NAME: **DOB:**

COLON CANCER SCREENING

*See Patient Questionnaire for more information **(Page 2)**

Has patient had a colon cancer screening performed in one of the following ways?

Current Active Diagnosis of Colon Cancer
☐Yes **C18.0-C18.9**
☐No

☐ ***NOT ELIGIBLE*** *- Documentation of diagnosis of colorectal cancer or total colectomy* ***G9711*** *or Patient is 65 and older in Special Needs Plans or residing in Long-Term Care* ***G9901***

☐ Colorectal cancer screening results documented and reviewed ***3017F***
- ☐ Fecal Occult blood test, immunoassay (within 1 year)
- ☐ Fecal Immunochemical DNA test (FIT-DNA) (within 3 years)
- ☐ CT Colonography (within 5 years)
- ☐ Flex Sigmoidoscopy (within 5 years)
- ☐ Colonoscopy (within 10 years)
  - ☐ **Test Results:**
    - ☐ **Normal**
    - ☐ **Abnormal**

BREAST CANCER SCREENING (WOMEN ONLY 50-74 YEARS)

*See Patient Questionnaire for more information **(Page 2)**

Has this patient had a mammogram performed in the last 27 months with documented results discussed with the patient?
☐ **Active Breast Cancer Left Female C50.912**
☐ **Active Breast Cancer Right Female C50.911**
☐ **Active Breast Cancer Left Male C50.922**
☐ **Active Breast Cancer Right Male C50.921**

_____/_____/_____
Date of last Mammogram

☐ Documented and reviewed ***G9899***
☐ ***NOT ELIGIBLE*** *- Documentation of bilateral mastectomy or 2 unilateral mastectomies* ***G9708***
OR *Patient is 65 and older in Special Needs Plans or residing in Long-Term Care*
☐ No

DEPRESSION SCREENING

If patient is depressed, please schedule a follow-up appointment within 10 to 14 months from today.

*See Patient Questionnaire for more information **(Page 3)**

Was the patient screened for depression?
PHQ-9 Score _____
☐ ***NOT ELIGIBLE*** *- Documentation that the patient is not eligible due to patient refuses to participate, situations where the patient's functional capacity or motivation may influence the accuracy of the assessment, such as: Patient has an active diagnosis of Depression; Patient has a diagnosed Bipolar Disorder, and certain court appointed cases or cases of delirium.* ***G9717***

☐ Yes
☐ No

If Yes, was the patient positive for depression?
☐ **Single Episode or unspecified F32.9**
☐ **5-9 Mild recurrent F33.0**
☐ **10-14 Moderate recurrent F33.1**
☐ **15-19 Moderately Severe Recurrent w/o psychotic symptoms F33.2**
☐ **20-27 Severe recurrent w/psychotic symptoms**
☐ **recurrent in partial remission F33.41**
☐ **recurrent in full remission F33.42**

☐ Yes and Follow-up plan documented **G8431**
☐ No **G8510**

If positive, please describe the plan to address the depression:

_____

_____

_____

DEPRESSION REMISSION

*See Patient Questionnaire for more information **(Page 3)**

Does the patient have an active diagnosis of major depression or dysthymia?	☐ Yes **G9717** ☐ No
If yes, did they score greater than a 9 on a PHQ-9 test, between 12/1/2018 thru 11/30/2019?	☐ Yes ***G9511*** ☐ No
If yes, did the patient receive a follow-up PHQ-9 test 10 – 14 months following the previous positive test with a score of 5 or higher?	☐ Yes ***G9510*** ☐ No ***G9509***

PATIENT NAME: **DOB:**

TOBACCO SCREENING

*See Patient Questionnaire for more information **(Page 3)**

Please review tobacco use and provide counseling if necessary.	☐ Currently Tobacco User and given cessation counseling **G9902+G9906** ☐ Currently NON-Tobacco User **G9903** ☐ ***NOT ELIGIBLE*** *–Documentation of medical reason(s) for not screening for tobacco use (e.g. limited life expectancy, other medicalreasons)* ***4004F with 1P or G9907***

ADL's and FALL RISK SCREENING

*See Patient Questionnaire for more information **(Page 3 & 4)**

Did the patient have 2 or more falls without injury or 1 or more falls with injury?	☐ Yes ***3288F, 1100F*** ☐ No ***1101F*** ☐ *NOT ELIGIBLE –Patient is not ambulatory* ***3288F with 1P, 1100F***
Activities of Daily Living / Functional Status Assessment completed?	☐ Yes **1170F** ☐ No ☐ *NOT ELIGIBLE –Patient is not ambulatory* ***3288F with 1P, 1100F***

DIABETES CONTROL (DIABETICS ONLY 18-75 YEARS OF AGE)

*See Patient Questionnaire for more information **(Page 2)**

Is this patient 18 to 75 years of age with Type 1 or Type 2 diabetes? ☐ Yes ☐ No

☐ **Diabetes Type 1 E10.9**
- ☐ **With CKD stage_E10.22, N18. _**
- ☐ **With Nephropathy E10.21**

☐ **Diabetes Type 2 E11.9**
- ☐ **With CKD stage__, E11.22, N18. __**
- ☐ **With Nephropathy E11.21**

Please report the patient's most recent HbA1c level: _____ _____/_____/_____

HbA1c level Date of screening

Has the patient had a retinal or dilated eye exam within 2020 through an Optometrist or Ophthalmologist?
☐ **Diabetic Retinopathy w/o Macular Edema E11.319**
☐ **Diabetic Retinopathy w/ Macular Edema E11.311**

→ ☐ Dilated eye exam with interpretation by optometrist or ophthalmologist. Documented and reviewed. ***2022F***
→ ☐ Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed ***2024F***
→ ☐ Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed ***2026F***

OR

A negative screening in 2019? → ☐ Low risk for retinopathy (no evidence of retinopathy in the prior year)* ***3072F***

OR

No screening in 2019 or 2020

OR

No screening in 2020, but positive screening in 2019? → ☐ Refer patient for a retinal or dilated eye exam

Has the patient had a diabetic nephropathy screening test within 2020?
- Timed, spot or 24-hr urine for microalbumin
- 24-hr urine for total protein
- Urine for microalbumin/creatinine ratio
- Random urine for protein/creatinine ratio

☐ Positive microalbuminuria test result documented and reviewed. ***3060F***
☐ Negative microalbuminuria test result documented and reviewed. ***3061F***

OR

Was there documented evidence of treatment for nephropathy within 2020?

☐ Documentation of treatment for nephropathy ***3066F***
☐ ACE/ARB prescribed ***4009F***

PATIENT NAME: **DOB:**

STATIN THERAPY

Is this patient 21 or older and diagnosed with clinical ASCVD?
☐ ASCVD w/Angina Pectoris I25.119

→ ☐ Yes ***G9662***
☐ No

OR

Is the patient 21 or older whose LDL-C was ***EVER*** >= 190mg/DL OR hx/active dx of familial or pure hypercholesterolemia?

→ ☐ Yes , LDL-C =>190mg/DL, **G9663**
☐ Yes, hx or dx of hypercholesterolemia**, G9782**
☐ No

OR

Is the patient aged 40-75 with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189mg/dL within 2018, 2019, or 2020?

→ ☐ Yes **G9666**
☐ No

Was the patient prescribed a statin therapy?

☐ Yes ***G9664***
☐ *NOT ELIGIBLE* – Documentation of medical reason(s) for not being a statin therapy user: (e.g., patient with adverse effect, allergy or intolerance to statin medication therapy, patients who have an active diagnosis of pregnancy or who are breastfeeding, patients who are receiving palliative care, patients with active liver disease or hepatic disease or insufficiency, patients with end stage renal disease (ESRD), patients with a dx of rhabdomyolysis, and patients with diabetes who have a fasting or direct LDL-C laboratory test result < 70 mg/dL and are not taking statin therapy) **G9781**
☐ No

Medications Reviewed

*See Patient Questionnaire for more information **(Page 1)**

☐ Medication review by prescribing care provider or clinical pharmacist documented **1160F**

Advanced Directives

Advance care planning including the explanation and discussion of advance directives such as standard forms by the physician or other qualified health care professional
Time spent in minutes: _____

☐ First 30 minutes **99497 and 1158F**
☐ Each additional 30 minutes ***99498***

Pain Assessment

*See Patient Questionnaire for more information **(Page 3)**

Pain Level on scale 1-10? _____

☐ No pain documented **1126F**
☐ Pain documented **1125F**

Rheumatoid Arthritis Assessment

*See Patient Questionnaire for more information **(Page 1)**

Does the patient have a diagnosis of Rheumatoid Arthritis?
☐ Rheumatoid arthritis without rheumatoid factor, unspecified site **M0600**
☐ Rheumatoid arthritis with rheumatoid factor, unspecified site **M059**

☐ If yes, are they taking a DMARD
☐ If they are not on a DMARD, do they have a referral to Rheumatology? No pain documented

PATIENT NAME: **DOB:**

THE MINI COGNITION TOOL (*You may utilize this tool or assess cognitive function by direct observation)*

Administration:

1. Instruct the patient to listen carefully to and remember 3 unrelated words and then to repeat the words. The same 3 words may be repeated to the patient up to 3 tries to register all 3 words.
2. Instruct the patient to draw the face of a clock, either on a blank sheet of paper or on a sheet with the clock circle already drawn on the page. After the patient puts the numbers on the clock face, ask him or her to draw the hands of the clock to read a specific time. The time 11:10 has demonstrated increased sensitivity.
3. Ask the patient to repeat the 3 previously stated words.

Scoring:

- (Out of total of 5 points) Give 1 point for each recalled word after the CDT distractor. Recall is scored 0-3.
- The CDT distractor is scored 2 if normal and 0 if abnormal. (Note: The CDT is considered normal if all numbers are present in the correct sequence and position, and the hands readably display the requested time. Length of hands is not considered in the score.)

Interpretation of Results: (Please circle one)
0-2: Positive screen for dementia
3-5: Negative screen for dementia

PERSONALIZED PREVENTION PLAN

Please provide patient with the following:

- Personalized prevention plan which may include:
    - Screening scheduling on preventive services that Medicare covers
    - Referrals to beneficial programs, such as fall prevention, exercise, etc.

Physician Signature:_____ Date: _____