COMMUNITY MEDICAL PROVIDERS
Medical Group

↑G0402 IPPE (Welcome)
↑G0438 – AWV (Annual)
↑G0439 - Subsequent

Version 4/18/2017

ANNUAL WELLNESS VISIT *(chief complaint)*

Office staff: Medical Record Number: _____ Date of Service_____

PLEASE PRINT:

Patient Name _____

Date of Birth _____ Gender ☐Male ☐Female

Race *(ex: Caucasian, Asian)*_____ Ethnicity *(ex: Italian, German)*_____

Medicare B Eligibility Date _____

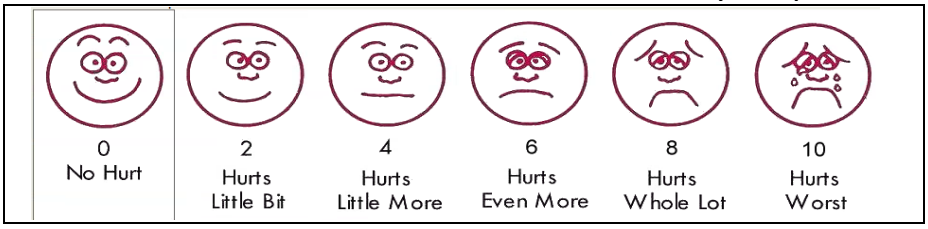
PAIN *(office: EPIC's vital signs – pain information)*

⇨Please circle your answers

How often is pain a problem for you?	Never	Sometimes	Often	Always

Where is your pain? _____

Circle one of the faces below that best relates to your pain:



- (Office: complete EPIC's hearing (simple screen)/vision, timed up and go)

ALLERGIES - Please list all allergies or reactions to medications *(office: EPIC's allergies)*

Allergy/Medication:	**Reaction:**
☐ No Allergies	

MEDICATIONS - Please list all medication you currently take including prescriptions, supplements, cold medication, aspirin, vitamins, and birth control pills. Please list all medication dosages and frequency taken. *(office: EPIC's medications)*

Medication	Dosage	Frequency
☐ I take NO Medications		

MEDICAL HISTORY - List all illnesses and injuries & when they started. (For example: asthma, diabetes, high blood pressure, heart murmur, epilepsy, cancer, depression, fatigue, accidents, fractures, head injuries, burns) *(Office: EPIC's medical history section & update problem list)*

Problem	Date

HOSPITALIZATIONS- other than for surgeries *(Office: EPIC's medical/surgical history section)*

Hospitalized for:	Date
☐ Never been hospitalized	

SURGICAL HISTORY -- List all surgeries & the date of surgery. *(For example: tonsillectomy, appendix, gallbladder, hernia, hysterectomy)* *(Office: EPIC's surgical history section)*

Surgery for	**Date**
☐ No Surgeries	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY for blood relatives *(Office: EPIC's family history section)*

Mother's age now _____ (or age at death) _____
Father's age now _____ (or age at death) _____

Has any immediate family member *(parents, brother, sister, grandparents, and children)* had:

Yes	**No**		**Which Family Member(s) / What Age:**
☐	☐	Alcoholism	_____
☐	☐	Asthma	_____
☐	☐	Cancer	_____
☐	☐	Depression	_____
☐	☐	Diabetes	_____
☐	☐	Drug Problem	_____
☐	☐	Heart attack	_____
☐	☐	High Blood Pressure	_____
☐	☐	High Cholesterol	_____
☐	☐	Stroke	_____
☐	☐	Other illness or conditions that run in your family	
		_____	

SOCIAL HISTORY *(Office: EPIC's social history section)*

Yes	No	
☐	☐	Do you drink alcohol?
☐	☐	If YES to drinks alcohol above, is it more than 4 drinks in 1 day or 28 in a week? How many drinks per week? _____ *(Office: If Yes to more than 4 alcoholic drinks per day or 28 per week perform AUDIT flowsheet)*
☐	☐	Have you used illegal drugs? Which ones: _____ *(Office: If Yes to illegal drug use, perform DAST flowsheet)*
☐	☐	Do you smoke? If yes, what type/ amount? _____ *(Office: If Yes to smoking, give Smoking Cessation Counseling)*

⇨Please circle your answers

What is your Marital Status?:	Single	Married	Widowed	Separated
What is your Occupation?:	Retired Y / N	If Employed Occupation:		

What was your highest level of education?_____
What are your hobbies? _____

Women Only: GYNECOLOGICAL HISTORY *(Office: EPIC's obstetric history section)*

Number of pregnancies _____
Number of miscarriages _____
Number of children _____
Number of abortions _____

Activities of Daily Living, ***Part 1 of 2*** *(Office: EPIC's ADL's section)*

Back Care?	Yes	No	Gun Owner?	Yes	No	Sleep Concern?	Yes	No
Bike Helmet?	Yes	No	Hobby Hazards?	Yes	No	Smoke Detectors?	Yes	No
Blood Transfusions?	Yes	No	Military Service?	Yes	No	Special Diet?	Yes	No
Body Piercings?	Yes	No	Occupational Exposure?	Yes	No	Stress Concern?	Yes	No
Caffeine Concern?	Yes	No	Seat Belt?	Yes	No	Tattoos?	Yes	No
Exercise?	Yes	No	Self-Exams?	Yes	No	Weight Concern?	Yes	No

DEPRESSION SCREEN *(Office: If Yes to either question, give PHQ 9 Form & complete EPIC PHQ Flowsheet)*

Yes	No	
☐	☐	Over the past two weeks, have you felt little interest of pleasure in doing things?
☐	☐	Over the past two weeks, have you felt little down, depressed or hopeless?

ACTIVITIES OF DAILY LIVING, *Part 2 of 2*

(Office: For next 2 pages, use PNA Annual Wellness Visit Flowsheet) (Provider: if needed, consider a Referral)

Yes	No	
☐	☐	Do you have a well-balanced diet? If no, why not? _____
☐	☐	How often do you exercise?_____ ____what type? _____
☐	☐	Do you drive? If not, who provides transportation?_____
☐	☐	Are you able to get on and off the toilet easily?
☐	☐	Do you have self-control over your bladder or bowel?
☐	☐	Do you need help with eating or meal preparation?
☐	☐	Do you need help shopping or doing light housekeeping?
☐	☐	Do you have difficulty doing errands alone?
☐	☐	Do you need help with dressing/bathing?
☐	☐	Do you have a problem functioning sexually?
☐	☐	Do you have any trouble hearing?
☐	☐	Do you have any trouble seeing, even with glasses?
☐	☐	How many hours can you be left alone? _____

COGNITIVE / FUNCTIONAL STATUS *(Provider: if needed, consider Referral)*

Yes	No	
☐	☐	Are you having trouble concentrating or making your own decisions?
☐	☐	Do you have trouble managing the mail or paying bills?
☐	☐	Are you having trouble ordering your medication or scheduling doctors appts?
☐	☐	Are you having trouble remembering to take your medications?
☐	☐	Do you have a decreased sense of direction?
☐	☐	During the past year, have you experienced confusion or memory loss that is happening more often or getting worse?

GENERAL LIFE SATISFACTION: *(Provider: if needed, consider a Referral or further testing)*

⇨Please circle your answers

How often do you get the social and emotional support you need?	Always	Usually	Some-times	Rarely	Never
During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors or groups?	Always	Usually	Some-times	Rarely	Never
During the past four weeks, was someone available to help you if you needed or wanted it?	Always	Usually	Some-times	Rarely	Never

⇨Please circle your answers

In general, how satisfied are you with your life:	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
How often is stress a problem for you?	Never	Some-	Often	Always

		times		

SAFETY SCREEN *(Office: If Yes for the fall questions (1&2), complete STEADI Fall Risk in Visit Navigator)*

Yes	No	
☐	☐	How many times have you fallen in the last Year?_____
☐	☐	Do you worry about falling?
☐	☐	Has anyone made you afraid or hurt you physically?
☐	☐	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?

Adult Activity Level - *For activity to be regular, it must add up to a total of 30 minutes or more per day and be done at least 5 days per week.* (Please mark 1 answer)

☐1	I currently do NOT exercise and do not intend to start exercising in the next 6 months.
☐2	I currently do NOT exercise, but am thinking about starting in the next 6 months.
☐3	I currently exercise some, but not regularly.
☐4	I currently exercise regularly, but I have only begun to do so in the last 6 months.
☐5	I currently exercise regularly, and have done so for longer than 6 months.

Do you receive health care from other physicians or sources?

(Office: add physicians to EPIC's care team, patient care team section, team member)

YES	NO	Specialty	Provider Name	Reason for Visit?	Last Visit Date?
☐	☐	Audiologist (Hearing)			
☐	☐	Cardiologist (Heart)			
☐	☐	Dermatologist			
☐	☐	Dentist			
☐	☐	Gastrointestinal (GI)			
☐	☐	Optometrist (Eye)			
☐	☐	Podiatrist (Feet)			
☐	☐	Medical Equipment			
☐	☐	Home Health			
Other:					

Health Maintenance *(Office: update EPIC's health maintenance section)*

• **Immunizations**	**Date Last Done**
Last tetanus shot	_____
Pneumonia vaccine	_____
Last flu shot	_____
Hepatitis B Series	_____
Zostavax	_____

• **Preventive Screenings**	**Date last done:**
Bone scan	_____
Colonoscopy	_____
Eye exam	_____
FOBT (Fecal Occult Blood Test)	_____
Mammography	_____
Pap smear	_____(Female only)

YES	**NO**	
☐	☐	**Do you have a POLST or Advanced Care Directive*?*** *(Office: EPIC's Directives section)*

(Office: Open SmartSet: "PNA Medicare Wellness Visit"

Who would be able to help you in case of illness or emergency?

Name: _____

Relationship?:_____

Phone #: _____

- Please sign here for your approval to send your healthcare information to the person listed above:_____*(your signature)*

This form was filled out by (please print your name):

Name: _____Relationship?

_____

Staff Signature –

Staff member conducting initial intake: _____ Date:_____

Provider Signature –

Review/notation of pertinent history performed: _____

Date:_____

★★★WE THANK YOU FOR YOUR VISIT TO OUR OFFICE★★★