ANNUAL WELLNESS VISIT

Demographic:

Patient Name: _____ **Date:** _____

DOB: _____ **SSN:** _____ **Sex:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone Number:** _____

Medicare Part B Eligibility: _____ **Date of Last AWV:** _____

Billing Codes

- ☐ **G0402** Initial preventive physical examination **(IPPE)** - face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
- ☐ **G0403** Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report
- ☐ **G0404** Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination
- ☐ **G0405** Electrocardiogram, routine ECG with 12 leads, interpretation and report only, performed as a screening for the initial preventive physical examination
- ☐ **G0438** Annual Wellness Visit - **Initial** with Personalized Prevention Plan of Services (PPS)
- ☐ **G0439** Annual Wellness Visit - **Subsequent** with Personalized Prevention Plan of Services (PPS)

Additional Billing Codes

- ☐ **99497** Advanced care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- ☐ **99498** Advanced care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- ☐ **96127** PHQ-2 or PHQ-9 Assessment
- ☐ **G8510** Screening for Depression is documented as negative, a follow-up plan is not required
- ☐ **G8431** Screening for depression is documented as positive and a follow-up plan is documented

(Do NOT bill without consulting your biller)

PAST/CURRENT MEDICAL HISTORY (check box for any "Yes" answers)		
☐ Muscle problems	☐ Hearing problems	☐ Stroke
☐ Abnormal Pap Smear	☐ Allergic Rhinitis	☐ Anxiety
☐ Alcohol/Drug abuse	☐ Suicide attempt	☐ Blood clots
☐ Bipolar Disorder	☐ Obesity	☐ Sleep Apnea
☐ Carotid Artery Disease	☐ Congestive Heart Failure	☐ Chronic Pain
☐ Chest pain	☐ Hepatitis or other liver disease	☐ High cholesterol
☐ CKD/Renal Disease	☐ Colon Polyps	☐ Skin disease or skin problem
☐ COPD or Emphysema	☐ Coronary Artery Disease	☐ Diabetes
☐ Crohn's or Ulcerative Colitis	☐ Insomnia	☐ Low Testosterone
☐ CVAD (Cerebral-Vascular Arterial Disease	☐ Dementia or Alzheimer's	☐ Anemia, Blood problems
☐ Dizziness or fainting spells	☐ Excessive bleeding after surgery or dental work	☐ Hearing aid/ pacemaker/ artificial limb/ other physical apparatus
☐ Epilepsy, seizures (convulsions)	☐ Pneumonia	☐ Malaria
☐ Erectile Dysfunction (ED)	☐ GERD/Acid Reflux	☐ Glaucoma
☐ Heart valve problems	☐ Arthritis	☐ Asthma
☐ Hip Fracture	☐ HIV/AIDS	☐ Thyroid disorders
☐ Hypertension	☐ Depression	☐ Cancer
☐ Migraines	☐ Diabetic Neuropathy	☐ Other Neuropathy
☐ Paralysis/ numbness/tingling	☐ Atrial Fibrillation	☐ Attention Deficit Disorder (ADD)
☐ Prostate Enlargement	☐ Chronic cough	☐ Tuberculosis or Positive TB Test
☐ Recurrent UTIs	☐ Kidney Stones	☐ Rheumatoid Arthritis
☐ Shortness of breath	☐ Hernia	☐ Diverticulitis
☐ Vitamin B12 deficiency	☐ Vitamin D deficiency	☐ Other (specify below)
Other:		

Please list all doctors or Specialists who are currently treating you.	
Provider's Name	Specialty and/or Clinic Name

Have you been hospitalized within the past year? Yes ☐ No ☐

If yes, please give details of your hospitalization.		
Hospital (Name and Location)	Reason for Hospitalization	Dates of stay

Please list any major surgeries/operations you have had in the past.	
Surgery/Operation	Date

CURRENT MEDICATIONS **Include all prescription, over-the-counter, vitamins, minerals, and herbal supplements.**		
Medication Name	Dose (pill, mL, mg, etc.)	Frequency and Route (1x/day by mouth)

Do you have any allergies? Yes ☐ No ☐

If Yes, please check all that apply:				
Anesthesia ☐	Codeine ☐	Penicillin ☐	Iodine ☐	Food ☐
Latex ☐	Morphine ☐	Sulfa ☐	Aspirin ☐	Bee Stings ☐
Other Allergies:		Reaction:		
1.				
2.				

FAMILY HISTORY

Check "Yes" to identify all illnesses/conditions in your blood relatives and indicate relationship.

☐ Check here if adopted or unknown family history

Illness/Condition	Yes	Relation (mother, father, brother, sister, grandparent, child)
Heart Disease	☐	
High Cholesterol	☐	
Stroke	☐	
Cancer	☐	
Diabetes	☐	
High Blood Pressure	☐	
Alcoholism	☐	
Liver disease	☐	
Depression or psychiatric illness	☐	
Genetic disorder (inherited)	☐	
Other:	☐	

Mother: Living or Deceased (circle one) If deceased, cause of death: _____

Father: Living or Deceased (circle one) If deceased, cause of death: _____

Number of Living Children:_____ Number of births (women only): _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐

Highest level of Education: _____

Occupation:_____ Retired ☐

Do you smoke? (cigarettes, cigars) Yes ☐ No ☐ Smokeless tobacco ☐

If yes, how many packs per day?_____

Are you interested in quitting? _____

If you have quit, how long ago?_____

Do you drink alcohol? Yes ☐ No ☐

If yes, how often do you drink?_____

If you have quit, how long ago?_____

Do family or friends worry about your alcohol intake? _____

Do you currently use recreational drugs, including prescription medications? Yes ☐ No ☐

If yes, which drugs do you use?_____

Have you ever had problems with drug use, including prescription medications? Yes ☐ No ☐

If yes, have you received treatment? Yes ☐ No ☐

ACTIVITIES OF DAILY LIVING Please indicate your current level for each activity:				
Bathing	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Dressing	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Grooming	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Oral Care	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Toileting	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Transferring	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Walking	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Climbing Stairs	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Eating	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Shopping	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Cooking	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Managing Medications	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Using the Phone	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Housework	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Doing Laundry	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Driving	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do
Managing Finances	☐ Independent	☐ Needs Help	☐ Dependent	☐ Does Not Do

Considering your age, how would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How is your hearing: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Deaf ☐ Hearing Aids/Device:_____

How is your vision: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Uses Glasses ☐ Uses Contacts

☐ Cataract (s) ☐ Glaucoma ☐ Macular Degeneration ☐ DM Retinopathy ☐ Blind

When was your last eye exam?_____Eye doctor: _____

***VACCINATIONS**

Please check the box for any vaccinations you have received and indicate the date received.

Vaccine	Received	Date Received
Flu	☐	
Pneumococcal (Pneumonia)	☐	
Hepatitis B	☐	
Shingles	☐	
Tetanus	☐	

Are you worried about your memory? Yes ☐ No ☐

Do you have a living will or advance directive? Yes ☐ No ☐ **If yes**, please provide a copy for your health record.
If no, would you like information on creating one? Yes ☐ No ☐

Have you had a colonoscopy? Yes ☐ No ☐ **If yes**, date received:_____

Have you had a mammogram? Yes ☐ No ☐ **If yes**, date received:_____

Do you exercise? Yes ☐ No ☐ **If yes**, how often? ☐ Daily ☐ 4 – 6x a week
☐ 1 – 3x a week ☐ less than one time a week
What form of exercise? (e.g., jogging, cycling, swimming)

_____

Do you follow a special diet? Yes ☐ No ☐ **If yes**, specify:_____

How would you rate the foods you typically eat? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Do you use seat belts consistently? Yes ☐ No ☐

Do you practice safe sex? Yes ☐ No ☐ **If no,** have you been tested for HIV/AIDS in the past year? Yes ☐ No ☐

Is violence at home a concern for you? Yes ☐ No ☐

Are you currently in a relationship? Yes ☐ No ☐

If yes, do you feel safe in this relationship? Yes ☐ No ☐

Have you fallen 2 or more times in the past 12 months?	Yes ☐	No ☐
Have you been injured in a fall within the past 12 months?	Yes ☐	No ☐

☐ **Yes** ☐ **No** 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 feel unsteady on your feet or shuffle when you walk?

☐ **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 experience incontinence? Bowel or Bladder? (circle one or both)

☐ **Yes** ☐ **No** 11) Do you currently use a cane or walker or have you ever been told you should?

During the past two weeks, have you often been bothered by any of the following problems?

1) Feeling down, depressed, irritable or hopeless? ☐ Yes ☐ No
2) Little interest or pleasure in doing things? ☐ Yes ☐ No

If you answered "Yes" to either of these questions, please complete the following questions. If you answered "No" to BOTH questions, go to the next page.

	***Over the last 2 weeks, how often have you been bothered by any of the following problems?**	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
				PHQ9 Total Score (office use only)	

LIVING WILL & APPOINTMENT OF HEALTHCARE SURROGATE

I, _____, want to choose how I will be treated by my physicians and other healthcare providers. If there comes a time when I am unable to communicate or make my own healthcare decisions because of illness or injury, I direct my physicians, my healthcare surrogate, and my family to honor this living will.

Part 1 – Appoint a Healthcare Surrogate

In the event I am unable to communicate or I am incapable of making decisions about receiving, withholding, or withdrawing medical procedures or other treatments, I designate my healthcare surrogate to make choices for me according to his/her understanding of my wishes and values.

My Appointed Healthcare Surrogate is:

Name: _____

Address: _____

Phone: _____ Alt Phone: _____

If my surrogate is unable or unwilling then my next choice (Alternate Surrogate) is:

Name: _____

Address: _____

Phone: _____ Alt Phone: _____

Part 2 – Indicate Your Wishes

I understand that this living will only becomes effective when I am no longer able to communicate or whne I am not capable of making my healthcare decisions. When two physicians have determined that I have one of the following:

- A terminal or end-stage condition, and there is little or no chance of recovery
- A condition of permanent and irreversible unconsciousness, such as a coma or vegetative state
- An irreversible and severe mental or physical illness that prevents me from communicating with others, recognizing my family and friends, or caring for myself in any way

Then I want my doctors and others to provide comfort (palliative) care including relief of all physical pain, suffocation and mental anguish. If I develop one of the above conditions, my treatment choices are:

My specific Choices if I have one of the Above Conditions	Yes, I want	No, I do not want
• Cardio-Pulmonary resuscitation (CPR) if my heart or breathing stops	☐ **Yes**	☐ **No**
• A breathing machine if I am unable to breathe on my own	☐ **Yes**	☐ **No**
• Nutrition and fluids through tubes in my veins, nose or stomach	☐ **Yes**	☐ **No**
• Kidney dialysis, a pacemaker or defibrillator, or other such machines	☐ **Yes**	☐ **No**
• Surgery or admission to a hospital Intensive Care Unit	☐ **Yes**	☐ **No**
• Medications that can prolong my dying, such as antibiotics	☐ **Yes**	☐ **No**
• I want Hospice involved in my care at the earliest opportunity	☐ **Yes**	☐ **No**

If a medical decision has to be made for me and my decision is not indicated above, I want my healthcare surrogate to make and communicate these decisions for me.

Other Information (Optional):
Quality of life is important to me. These are the things that give my life quality:

Part 3 – Make It Legal

I fully understand the meaning of this declaration, I am emotionally and mentally competent to make this declaration, and have given this declaration careful consideration.

_____ _____ _____
Print Name Signature Date

*Witness 1: _____ _____ _____
Print Name Signature Date

Address: _____

*Witness 2: _____ _____ _____
Print Name Signature Date

Address: _____

*Your healthcare surrogate(s) can not serve as a witness to this living will.
At least one witness must be someone other than your spouse or a blood relative.

Height:_____ Weight: _____ BMI:_____ ☐ Normal

☐ Overweight
☐ Underweight

Blood pressure:_____

Date of last HgbA1C:_____Value:_____

If patient has CAD, is patient on ACE or ARB? ☐ Yes ☐ No

If patient has IVD, is patient on aspirin or antithrombotics? ☐ Yes ☐ No

If patient has LDL-C ≥ 190, is patient on statin? ☐ Yes ☐ No

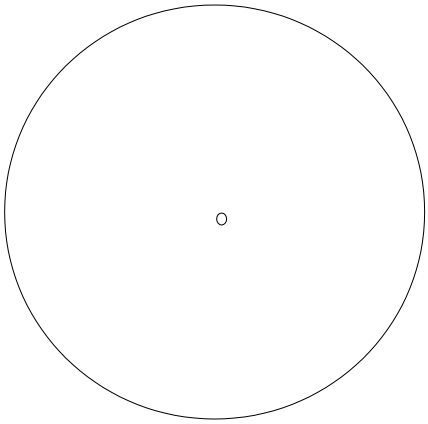
If patient has HF, is patient on beta-blocker? ☐ Yes ☐ No

If "No" to any of these questions, med must be prescribed by authorized provider OR documentation of contraindication, allergy, or adverse effect.

MEMORY/COGNITION/GAIT

1. Ask the patient to remember Apple, Penny, Table.
2. Observe gait: Ask patient to stand, walk across the room and back, and sit down. If they can do this in 20 seconds, gait is probably OK. Is gait normal? ☐ Yes ☐ No
3. Ask to recall the items above. Remembered 1 2 3 items
4. Ask patient to draw the hands on the clock at 3:00.

Draw a clock OK? ☐ Yes ☐ No



☐ Areas of concern within the Annual Wellness Visit have been addressed, counseling has been offered, and a Personalized Prevention Plan has been covered with patient.

Signature &Title of Medical Professional:_____Date:_____

Personalized Prevention Plan

Based on the results of your Annual Wellness Visit with

Dr._____on_____, the following has been recommended for you:

Preventive Health Services	
Recommended	Notes, Dates, Referred to
☐ Mammogram	
☐ Bone Density scan	
☐ Colonoscopy	
☐ Flu shot	
☐ Pneumonia shot	
☐ Shingles vaccine	
☐ Other vaccination	
☐ Blood work:	
☐ Cholesterol	
☐ Hemoglobin A1C	
☐ CBC (complete blood count)	
☐ Other	
☐ PSA	
☐ Pelvic Exam/Pap	
☐ Vision check	
☐ Other	

In addition, your doctor recommends that you receive counseling on the following and can either schedule an appointment for you to return for this counseling or can refer you to someone else who can help:

Counseling Recommended on:	
Topic	Notes, Dates, Referred to
☐ Nutrition / Healthy Eating	
☐ Weight Loss	
☐ Diabetic Meal Planning	
☐ Other Special Diet	
☐ Physical Activity / Exercise	
☐ Depression / Mental Health	
☐ Smoking Cessation	
☐ Alcohol Abuse	
☐ Drug Abuse	
☐ Pain Management	
☐ Fall Prevention / Safety at Home	
☐ Advance Directive	
☐ Other	
☐ Other	

If you have any other questions about your health, please be sure to speak with your Healthcare Provider. We hope you were pleased with your Annual Wellness Visit and Wellness Plan. We look forward to discussingthis again next year or any time you visit our clinic.

Please place copy of PPP in medical record before giving to patient}

Signature &Title of Medical Professional:_____ Date: _____