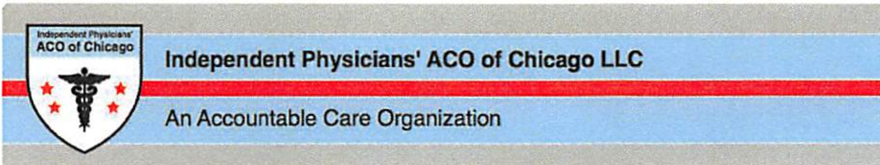

Annual Health Assessment

DATE:_____/_____/_____

Member Name:____________________Provider Name_______________ AGE:_____

DOB:____/____/_____ Gender: ☐ M ☐ F

Race: ☐W,☐B, ☐H, ☐A, ☐ AI

Marital Status: ☐ M ☐D ☐W ☐Sep ☐ Single

Ethnicity:_____________Language:_______________

Sexual Orient: ☐Hetero ☐ Homosexual ☐ Bisexual

Wellness Exam LAST YEAR ☐ N ☐Y _____/_____/_____

Chief Complaint/HPI: ☐ **Wellness Exam**

List Dx & Hospitalizations LAST 12 MONTHS ☐ None ☐ Yes (list below) Month/Year

1.____

2.____

3.____

4.____

Were you discharged from hospital/ECF/Rehab unit in last 30 days? ☐YES ☐ NO

Did you receive Influenza Flu Vaccine last season? ☐YES ☐ NO

Did you ever received Pneumonia vaccine(65yo & older)? ☐YES ☐ NO

If yes, approximately when ________/____________

Did you refuse Pneumonia vaccine? ☐YES ☐ NO

Do you presently use tobacco? ☐YES ☐ NO

If yes, how much do you smoke? ____________

Smoking Cessation Tx plan ☐YES, Handout Given ☐YES

Prescribed Smoking Cessation Meds: ☐YES ________________________

Have you had a Colonoscopy(50-75yo) in the last 10 years? ☐YES ☐ NO

Have you had a Mammogram(40-74yo) in the last 24 months(2014-15) ☐YES ☐ NO

If Yes, what date/facility:________________/________________________

In general, would you say your health is

☐Excellent, ☐Very good, ☐ Good, ☐ Fair, ☐ Poor

In the past 7 days, how much pain have you felt? ☐ None, ☐ Some, ☐ A Lot

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☐ **List of PMHx & FAMILY HISTORY were reviewed & updated in EMR**

PMHx & FAMILY HISTORY	Patient	Father	Mother	Sibling(s)	Grandfather	Grandmother
Deceased	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer (________________)	☐	☐	☐	☐	☐	☐
Cancer (________________)	☐	☐	☐	☐	☐	☐
Cancer (________________)	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐
Asthma/COPD	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐
Hypercholesterolemia	☐	☐	☐	☐	☐	☐
________________	☐	☐	☐	☐	☐	☐

☐ **List of Operations/ Surgeries were reviewed & updated in EMR**

Please Check Below Any Prior Operations & Site(Right or Left) & Include Year________:

- ☐ No prior operations
- ☐ Tonsillectomy & Adenoidectomy_______
- ☐ Appendectomy _______
- ☐ Hernia_______
- ☐ Cholecystectomy(Gallbladder Removed)________
- ☐ Total Abdominal Hysterectomy(Uterus removed)_______
- ☐ Bilateral Oophorectomy(Ovaries removed)__________
- ☐ Vaginal Hysterectomy(Uterus removed via Vagina)________
- ☐ Cesarean Section_______
- ☐ Total Knee Replacement_________
- ☐ Total Hip replacement_________
- ☐ Arthroscopy Knee(Scope of Knee)__________
- ☐ Tubal Ligation(Tubes tied)______
- ☐ Carpal Tunnel Surgery_________
- ☐ CABG(open Heart Surgery Bypass)________________
- ☐ Cardiac Valve Replacement(Open heart to replace valve)______
- ☐ Pacemaker_______
- ☐ Carotid Endarterectomy_____
- ☐ AAA Repair(Abdominal Aortic Aneurysm Repair)_______

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☐ Breast Masectomy________________
☐ Breast Lumpectomy________________
☐ Colon Resection(Removal of Colon)_________
☐ Cataract Surgery___________
☐ Glaucoma Surgery___________
☐ ____
☐ ____
☐ ____

****

OPTIONAL SECTION FOR PHYSICIAN TO COMPLETE BELOW:

☐ T & A _______	☐ __ Hip Rpl____	☐ AAA Repair____	☐ __Masectomy__
☐ Appendectomy____	☐ __CarpelTS___	☐ __Arthroscopy__	☐__Lumpectomy__
☐ Cholecystectomy___	☐ __CarotidEnd__	☐ __Cataract____	☐ TAH____
☐ ___Hernia_____	☐ C- Sect_______	☐ __BreastBx___	☐TAH & BSO____
☐ CABG__________	☐ ___TKR______	☐ Tubal Lig_____	☐Vag Hyst______
☐ Pacemaker______	☐ ____________	☐____________	☐____________

☐ **Medication List/ meds were reviewed & reconciled & updated in EMR**

Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

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☐ LIST of Providers reviewed & updated in EMR

Please **List any of your Providers** that you may recently have visited:

1.____
2,____
3.____
4.____
5.____
6.____
7.____

☐ Review of Systems performed & reviewed & updated in EMR

Please **Circle** any of the following symptoms that you may recently have had:

Con: wt loss-, wtgain-,anorexia-,fatigue-,weakness-,fever-,sweats-,chills-,insomnia-
Skin:Rashes-,itching-,bruising-,bleeding disorders-,swollen glands-,
Head: headache-,loss of consciousness-,seizures-,Hx trauma
Eyes: Change in vision-,eye pain-,redness-,double vision-,nose bleeds-,
Ears: dizziness-,loss of hearing-,ringing in ears-,discharge from ears-,
Resp: coughing-,sore throat-,shortness of breath-,coughing blood-,
Breast: swelling-,lumps-,discharge-
Cardio: chest pain-,palpitations,-SOB-,swelling in legs,leg cramps
Gastro: Abd. pain-,heartburn-,nausea-,vomiting-,rectal bleeding-,diarrhea-,constipation
GU: frequent urination-,urgency-,painful urination-,blood in urine-,incontinence-,discharge
MSK: joint pain-, joint swelling-,joint stiffness-, back pain

OPTIONAL GYNE SECTION:
GYNE SECTION
Menopausal ☐ YES ☐ NO
Menstrual: Age began_________ age ended_______
cycle length______days/duration____ regular.irregular_____
Date last mammogram________ date last pap smear________ date last period_________
How many pregnancies?______How many deliveries?_____ How many miscarriages_____
G______P______A______

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☐ Depression Screen performed & reviewed & updated in EMR

How much of the time have you:	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/ staying asleep/sleeping	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite	0	1	2	3
6. Feeling bad about yourself--or that you are a failure or have let yourself or others down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV	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
For office coding	_____	+ _______	+ ________	+ ________

Total score________

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? please circle

☐Not difficult at all ☐somewhat difficult ☐ very difficult ☐extremely difficult

Depression **Negative** Score ☐ Minimal (0-4)

Positive Score ☐ Mild (5-9) ☐ moderate (>10) ☐ severe(>15)

Tx Plan: ☐ Psychiatry Consult ☐ Antidepressant ☐ Counseling ☐ Follow-Up

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☐ Fall Risk Screening performed & reviewed & updated in EMR

Did you experience any falls in the last year? ☐ YES ☐ NO
If yes, how many times?____
Did any falls in the last year result in any significant injury? ☐ YES ☐ NO
If yes, what injury?____

	NO 0 point	YES 1 point
1.Diagnosis (three Dx that increases risk falls) a.______________b.______________c.___________	☐ 0	☐ 1
2. Hx of falls last 12 months ☐ None How many __	☐ 0	☐ 1
3. Incontinence	☐ 0	☐ 1
4.Visual impairment	☐ 0	☐ 1
5.Impaired functional mobility	☐ 0	☐ 1
6.Environmental Hazards(eg. stairs,rugs,bathtub)	☐ 0	☐ 1
7.Polypharmacy(4 or meds)	☐ 0	☐ 1
8.Chronic pain affecting level of function	☐ 0	☐ 1
9.Cognitive impairment(alzheimer's,dementia)	☐ 0	☐ 1

Total Points (4 or more is considered at risk) ____________

Fall Risk: ☐ **Negative(<3) NO Plan** ☐ **Positive(>4) Tx Plan**

Tx Plan: ☐ Physical therapy assessment
☐ Gait Strengthening
☐ Occupational Therapy
☐ Re-Assessment Meds
☐ Rehab Consult
☐ Reassessment Home Environment
☐ Bathtub Brace

Ambulatory Status: ☐cane ☐walker ☐wheelchair ☐ bedbound
☐ Independent

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☐ Activities of Daily Living performed & reviewed & updated in EMR

Activities of Daily Living:	Independent	Dependent	Comment
1. Bathing	☐	☐	____________
2. Dressing/Undressing	☐	☐	____________
3. Preparing Meals	☐	☐	____________
4. Eating	☐	☐	____________
5. Transferring bed/chair	☐	☐	____________
6. Control urinary continence	☐	☐	____________
7. Control fecal continence	☐	☐	____________
8. Use of toilet	☐	☐	____________
9. Ambulating	☐	☐	____________
10.Transportation	☐	☐	____________
11. Current Physical Activity	☐	☐	____________

Fully Independent ☐ YES
☐ NO, Needs Assistance

PLAN: ☐ social worker
☐ Meals on Wheels
☐ Home Health Agency
☐ Family Support

☐ Cognitive Assessment performed & reviewed & updated in EMR

Orientation: ☐ YES ☐ NO Times X 3 2 1 or 0

Able to recall the following items earns 1 point::

1. Day of the week	☐ 1	☐ 0
2. Month of the Year	☐ 1	☐ 0
3.Year	☐ 1	☐ 0
Three item recall		
4. Ball	☐ 1	☐ 0
5. Tree	☐ 1	☐ 0
6. Flag	☐ 1	☐ 0

Total Score ____________

Impaired
Cognitive Impairment ☐**NO** (5 or 6) ☐ **YES**(<4) Tx Plan

Tx Plan: ☐ Neuro consult ☐ Geriatric Consult
☐ Psych Consult ☐ Social Services Consult

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EXAM:

VS: BP ______/___ PR ______, RR_____, Temp _______F

Height:_____" weight:_______lbs BMI;_______(23-30 >65yo)

Visual Acuity: R Eye vision ____
(**Welcome visit**) L Eye vision _____

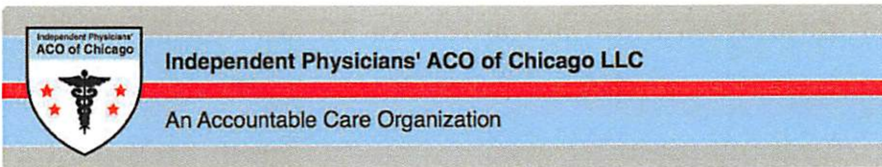
BMI ☐ Normal(23-30) ☐ Abnormal BMI Plan

*BMI was abnormal and patient was given instructions on how to ☐ increase or ☐ decrease weight based on a. Dietary modifications, b. Dietary supplements, c. Exercise program, dietary, and nutrition consultation, and given appropriate handouts and educational material reflecting the above.

Health Maintenance Treatment Plan:

CONDITION	DESCRIPTION	Ordered/ PLAN
Abdominal Aortic Aneurysm	U/S (men 65-75 Smokers)	☐ ________
Alcohol misuse of counseling	One misuse screening per year	☐ ________
Bone mass measurement	Once every 24 months	☐ ________
*CAD	Beta Blocker(CAD S/P MI)	☐ ________
*CAD	Statin prescribed	☐ ________
CAD/CHF	Beta Blocker(CAD EF<35%)	☐ ________
Cardiovascular Disease	Annual CAD (LDL_Chol<99)	☐ ________
Cardiovascular Disease	Aspirin therapy,	☐ ________
Cardiovascular Disease	Healthy eating	☐ ________
Cardiovascular Disease	(behavior Therapy & stress)	☐ ________
Cardiovascular Disease	check BP	☐ ________
Cardiovascular Screening	Lipid profile screening q 5 yrs	☐ ________
*CHF	LVF assessment	☐ ________
	ACE or ARB prescribed	☐ ________
DM/CAD	ACE or ARB prescribed	☐ ________
*Colon cancer screening(50-80	Fecal occult blood (annual)	☐ ________
	Colonoscopy (Q 10 yrs)	☐ ________
	Flexible sigmoidoscopy (Q 5 yrs)	☐ ________
*COPD	Spirometry (new COPD dx)	☐ ________
Diabetes screening	Fasting Glucose/ Hgb A1C	☐ ________
*Diabetes Chronic Disease Management	*LDL (Annual target<99)	☐ ________
	Microalbumin/Cr ratio(<30)	☐ ________

	*ACE or ARB(HTN with DM)	☐	________
	Retinal Eye Exam (annual)	☐	________
	*HgA1C testing (<8.0)	☐	________
	Foot Sensory Exam	☐	________
	Nutrition consult/ Dietician	☐	________
Diabetes self mgmt training	Requires physician order	☐	________
EKG Screening	Screen	☐	________
*Influenza Vaccine	Annual Flu Shot	☐	______
Hepatitis B Vaccine	High or medium risk individuals	☐	______
HIV Screening	Pregnant, at risk or upon request	☐	______
Hypercholesterolemia	Tx hyperlipidemia(LDL-C<99)	☐	______
*Mammogram	One every 24 months (age 50-74)	☐	______
Medical Nutrition Therapy	CKD or renal transplant (<6m)	☐	______
Obesity	Nutrition Consult	☐	______
	Exercise Program	☐	______
Osteoporosis Management	Bone Density Scan	☐	______
	Osteoporosis Tx	☐	______
Pap smear/pelvic exam	Q 3 years (thru age 65)	☐	______
Pneumonia Vaccine	One dose (age 65 and over)		
Prostate cancer screen(50yo>)	Digital Exam	☐	______
	PSA	☐	______
*Rheumatoid Arthritis Management	Prescribed DMARD	☐	______
Sexually Transmitted Infection	Chlamydia,	☐	______
	gonorrhea,	☐	______
	syphilis,	☐	______
	Hepatitis B	☐	______
	HIV	☐	______
(ST) screening	(high risk individuals)	☐	______
*Smoking Cessation Counseling	Current smokers(Counseling)	☐	______
	Nicotine Patch/ Gum	☐	______



☐ Assessment/Problem List/ Diagnosis performed , reviewed & updated in EMR

☐ Treatment plan performed & reviewed & updated in EMR

Assessment/Problem List/ Diagnosis/ Treatment Plan

* ______________________________
* ______________________________
* ______________________________
* ______________________________
* ______________________________
* ______________________________
* ______________________________
* ______________________________
* ______________________________
* ______________________________
* ______________________________
* ______________________________

Dx Code: ☐ Z00.01

☐ **Welcome to Medicare Visit**	**G0402**	**~$150**
☐ **New Annual Wellness Visit (2nd yr)**	**G0438**	**~ $180**
☐ **Annual Wellness exam**	**G0439**	**~$117**

Examiner Name(Please Print):______________________________

Examiner Signature:______________________________

Supervising Physician Name(if applicable):______________________________

Supervising Physician Signature:______________________________