MEDICARE ANNUAL WELLNESS VISIT (AWV)

Name: _____ DOB: _____ Date**:** _____
Sex Assigned At Birth: _____ Gender: _____

Has anything changed in regards to your health in the past year? *(New illness, surgeries, new medication allergies or intolerances etc.)*

_____

Have there been any significant changes in your life in the past year such as i*ncreased stress, new job, home, relationship, children, ill relatives, etc.?*_____

Have any of your blood relatives developed any new illnesses in the past year? If any blood relative has had cancer, please list their relation to you, what they had, and how old they were when diagnosed:

_____

If you have had any vaccines in the past year, please list them & the approximate date(s):

_____

What is (or was) your occupation: _____ Spouse's occupation:_____
If you are retired, what year did you retire? _____
If you have children, what are their names & ages?

_____

Do you currently use tobacco? ❑ Yes ❑ No What kind(s)? ❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Vape ❑ Chew
If yes, how much do you smoke (use) daily?

_____

If no, have you ever used tobacco? ❑ Yes ❑ No What kind(s)? ❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Vape ❑ Chew
If yes, how many packs per day did you smoke? _____ How many years did you smoke? _____
Year Quit _____
Any exposure to secondhand smoke (others smoking around you) currently or in the past? ❑ Yes ❑ No
If yes, please explain: _____
Do you currently use recreational drugs (like marijuana, etc)? ❑ Yes ❑ No
Do you wear a seatbelt? ❑ Yes ❑ No ❑ Occasionally
Do you exercise regularly? ❑ Yes ❑ No If yes, what do you do for exercise and how often?

_____

Please describe your diet

_____

Have you had a new sexual partner in the past year? ❑ Yes ❑ No
Would you like to be tested for HIV or other STDs? ❑ Yes ❑ No
Do you have any difficulties with hearing that limits your personal life? ❑ Yes ❑ No
Do you see a dentist at least once a year? ❑ Yes ❑ No

During the past 4 weeks, how would you rate your health? ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

Do you have any difficulties driving your own car or getting transportation if you do not drive? ❑ Yes ❑ No

During the past 4 weeks, was someone available to help you if you needed and wanted help? ❑ Yes ❑ No
Have you fallen 2 or more times in **the past year**? ❑ Yes ❑ No Are you afraid of falling? ❑ Yes ❑ No

Are you able to handle the following activities without help?

Shopping for groceries or clothes: ❑ Yes ❑ No

Preparing your own meals: ❑ Yes ❑ No

Doing housework: ❑ Yes ❑ No

Handling your money: ❑ Yes ❑ No

Keeping track of medications: ❑ Yes ❑ No

Bathing or dressing: ❑ Yes ❑ No

HEALTHCARE WISHES:

Do you already have a healthcare proxy or living will? ❑ Yes ❑ No

Are you willing to be an organ donor? ❑ Yes ❑ No

Most healthy patients would like to be treated aggressively (CPR, respirator, ICU, etc) if they had a potentially curable condition. If you had a condition that had no chance of recovery, would you wish to remain on life support? ❑ Yes ❑ No ❑ Not Sure

If you were unable to make your own healthcare decisions *(for instance, you were in a coma from a car accident)*, whom would you like us to ask about what your wishes would be? Please name one person and one alternate.
Name: _____ Phone #: _____ Relationship to You: _____
Name: _____ Phone #: _____ Relationship to You: _____

Please list any other physicians you are currently seeing:

Name of Physician	Location	Reason

ANNUAL HEALTH SCREENINGS:

PHQ-9 **Over the last 2 weeks, how often have you been bothered by any of the following problems?** ***(Please ✓ the appropriate box)***	Not at All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts that you would be better off dead or of hurting yourself in some way				
If you checked off any problems listed above, 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** your answer)*	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

S: _____ Dx: _____

AUDIT-C Please **circle** your answers:	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times a month	2 - 3 times a week	4 or more times a week
How many standard drinks containing alcohol do you have on a typical day when you drink?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

S: _____ Dx: _____

SOCIAL DETERMINANTS OF HEALTH

Personal Characteristics:

Have you been discharged from the Armed Forces of the United States?

Do you receive care from a VA clinic?

What is the name and address of the VA clinic you attend?

Name: Address:

State: City: Zip: Phone:

Do you need more assistance at home than you currently receive?

Family & Home:

What is your living situation today?

Money & Resources:

In the past year, have you or any family members you live with been unable to get any of the following, when you really needed them? Choose any that apply.

- ☐ Food/Groceries
- ☐ Housing
- ☐ Medications
- ☐ Money
- ☐ Transportation
- ☐ Healthcare/Treatment
- ☐ Other _____

In the past 2 months, did you or others you live with eat smaller meals or skip meals because you did not have money for food?

Are you confident using a computer, tablet, or phone for healthcare visits or finding information?

Has a lack of transportation kept you from medical appointments, meetings, work, or from getting items you need for daily living? If yes, please explain.

Additional Questions:

Do you feel physically and emotionally safe where you currently live?

The following pages are for staff & provider use, only

Social Needs:

To help determine if you may be eligible for government-sponsored financial assistance programs, I need to ask about your income. Are you ok with this?	☐ Yes ☐ No
Is your monthly income less than $1500.00 per month ($2000.00 per married couple), including Social Security?	☐ Yes ☐ No
☐ Support Groups – Alzheimer's	
☐ Support Groups – Cancer	
☐ Respite Care	

FALLS RISK ASSESSMENT

Clinician to ask the following questions and check "Yes" or "No" accordingly:

☐ Reviewed, no change		
☐ Yes	☐ No	Have you fallen in the past year?
☐ Yes	☐ No	Do you use or have you been advised to use a cane or walker to get around safely?
☐ Yes	☐ No	Have you lost some feeling in your feet?
☐ Yes	☐ No	Do you feel unsteady when walking?
Total		_____

1: If score is less than 3: Low Risk

- Document on AYPCP and advise patient to communicate with provider if fall risk worsens
- Provide Falls & Fractures education brochure
- No other assessment needed at this time

2: If score is 3 or 4: Moderate to High Risk

- Document on AYPCP and in the non-urgent collaboration section
- Provide member education
- Provide Falls & Fractures education brochure
- Call PCP if clinically indicated

3: If score is 5 or greater: High Risk

- Document on AYPCP and in the urgent referral section
- Provide member education
- Provide Falls & Fractures education brochure

Reason:

Education Topics: bone density screening, vision screening, medication review, physical therapy, exercise, home safety measures such as grab bars and tripping hazards, feet and footwear check.

COMPREHENSIVE PAIN ASSESSMENT

☐ Reviewed, no change		
☐ Unable to assess	**Reason:**	
☐ Pain?	☐ Yes	☐ No

Type of Pain:

Acute Pain – Pain comes on quickly, can be severe, lasts a relatively short period of time	☐ **Yes**
Chronic Pain – Pain that extends beyond the expected period of healing, usually greater than 6 months	☐ **Yes**
Location(s) of Pain:	

Description of Pain:

On a scale of 0-10:

- ☐ 0 – No pain
- ☐ 1-3 – Mild pain
- ☐ 4-7 – Discomforting-Moderate pain
- ☐ 8-10 – Distressing, Intense, Unbearable – Severe pain

Pain Score:

Now: _____ At Best: _____ At Worst: _____ Pain Goal: _____

Pain Evaluation:

1. What makes your pain better? _____
2. What makes your pain worse? _____
3. How would you describe how much your pain has been relieved in the past week?
   _____
4. Is the amount of relief you are receiving high enough to make a real difference in your life?
   - ☐ Yes
   - ☐ No
5. Are you meeting your pain goals?
   - ☐ Yes
   - ☐ No

Practitioner Assessment of Pain:

- ☐ Controlled the best it can be
- ☐ Controlled with medications
- ☐ Controlled without medications
- ☐ Uncontrolled and needing further pain management evaluation

MINI-COG ASSESSMENT

☐ Patient Refused

☐ Unable to Assess

This instrument combines an un-cued 3-item recall with a clock drawing test (CDT).

1. Instruct the patient to listen carefully and remember 3 unrelated words and to then repeat the words.
2. Instruct the patient to draw the face of a clock. After they put the numbers on the clock face, ask them to draw the hands of the clock to read a specific time. The instructions can be repeated, but no additional instructions should be given. Give the patient as much time as they need to complete the task. The exercise serves to distract from recall.
3. Ask the patient to repeat the 3 previously presented words.

Scoring: Give 1 point for each recalled word. Score 1-3.

A score of 0 indicates positive screen for Dementia.
A score of 1-2 with an abnormal clock draw test (CDT) indicates positive screen for Dementia.
A score of 1-2 with a normal CDT indicates negative screen for Dementia.
A score of 3 indicates negative screen for Dementia.

Clock Drawing:

☐ Normal
☐ Abnormal
☐ Unable to Perform

Patient's Score: _____

☐ Dementia
☐ Recommended further screening for Dementia

Progressive Medical Associates, PLLC
13220 Rosedale Hill Ave.
Huntersville, NC 28078
Phone: 704-766-0320 Fax: 704-766-0407

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient (Last, First): _____ Date of Birth: _____

Social Security Number: _____

I hereby request that my Medical Records be released to my Primary Care provider as follows:

Progressive Medical Associates, PLLC
13220 Rosedale Hill Ave.
Huntersville, NC 28078
Phone: (704) 766-0320
Fax: (704) 766-0407

Information to be Disclosed:

□ Complete Medical Record

OR

□ Progress Notes
□ Mental Health Records
□ Diagnostic Records Pertaining to _____
□ Lab Results
□ X-ray Reports
□ Hospital Records of Admission for Dates: _____to_____
□ Other:_____

I understand:

- This authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.
- Authorization for disclosures shall not condition treatment, payment, or eligibility for benefits. I may refuse to sign this authorization.

_____ _____
Signature of Patient Date

_____ _____
Printed Name of Patient Relationship of Patient Representative
(If signed by someone other than the patient)