ANNUAL WELLNESS VISIT – HEALTH RISK ASSESSMENT

DATE OF AWV: _____
DATE OF LAST AWV: _____
☐G0402 Welcome to Medicare
☐G0438 Initial Preventative Exam
☐G0439 Subsequent Preventative Exam

PERSONAL INFORMATION

Name	*DOB*

SPECIALISTS

NAME	*PHONE*	*REASON*

ER VISITS OR HOSPITALIZATIONS WITHIN THE LAST 12 MONTHS

DATE	*HOSPITAL*	*REASON*

SURGERIES WITHIN THE LAST 12 MONTHS

DATE	*SURGEON/FACILITY*	*REASON*

ANY RECENT CHANGES TO FAMILY HISTORY

FAMILY MEMBER (FATHER, MOTHER, SIBLING)	*DIAGNOSIS*

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you have any concerns about sexual function?	☐YES	☐NO
Are you concerned about sexually transmitted infections (STI)?	☐YES	☐NO
If so, would you like STI testing? ☐YES ☐NO		
Do you have any problems with urination, such as urinary leakage?	☐YES	☐NO
Do you have allergies not controlled with current medication regimen?	☐YES	☐NO
Do you feel safe at home?	☐YES	☐NO
Are you having any memory concerns?	☐YES	☐NO

TOBACCO AND DRUG USE SCREENING

☐Never smoked tobacco
☐Currently smokes tobacco #/day _____ Total Years Smoked _____
☐Formerly smoked tobacco #/day _____ Total Years Smoked _____ Date Quit _____

☐ Currently use marijuana/illicit drugs: Type of drug(s) _____ Frequency _____

☐1036F CURRENT NON-SMOKER
☐4004F CURRENT SMOKER
☐99406 COUNSELED & PLAN DOCUMENTED FOR TOBACCO CESSATION

ALCOHOL SCREENING

☐ Never drink alcohol
☐ Currently drink alcohol #/week _____ Type of Alcohol _____ Serving Size _____
☐ Formerly drank alcohol #/week _____ Total Years Drinking Alcohol _____Date Quit _____
Have you ever felt you should cut down on your drinking? ☐YES ☐NO
Have people annoyed you by criticizing your drinking? ☐YES ☐NO
Have you ever felt bad or guilty about your drinking? ☐YES ☐NO
Have you ever had a drink first thing in the morning to get rid of a hangover? ☐YES ☐NO

☐G0442 ALCOHOL SCREENING (FIRST 15 MINUTES SPENT)
☐G0443 ALCOHOL MISUSE CONSELING WITH DOCUMENTED PLAN

ACTIVITIES OF DAILY LIVING

Do you have any problems taking care of yourself or performing activities of daily living? ☐YES ☐NO
If yes, please describe:
_____
How would you rate your overall health: ☐ Poor ☐ Fair ☐Good ☐Excellent

EXERCISE SCREENING

Do you exercise regularly? ☐YES ☐NO If yes,
Duration _____ (example: 1 hr/day) Frequency _____ (example: 3 days/week)

PAIN ASSESSMENT

Are you having pain? ☐ YES ☐NO If yes, please state the location and frequency of the pain:
_____
_____
Please rate your pain on a scale of 1-10, with 10 being the worst. _____

If you are currently receiving treatment or taking any medication for your pain, please describe:
_____
_____

☐1126F NO PAIN PRESENT
☐1125F PAIN PRESENT WITH SEVERITY QUANTIFIED
☐0521F PAIN PLAN OF CARE DOCUMENTED

FALL RISK ASSESSMENT
Have you fallen within the last 12 months? If yes, how many times _____
If you sustained injury(ies) in the fall, please describe in detail:
_____
_____

LEAKAGE/INCONTINENCE – Are you having any urinary leakage/incontinence ☐YES ☐NO Describe _____
_____

ADVANCE CARE PLANNING - *Do you have any of the following:*
☐ Advanced Directives
☐ Living Will
☐ DNR
My surrogate decision maker is:

Name	*Phone*	*Relationship*

☐>15 MIN AND <44 MINUTES SPENT
☐99497 ADVANCE CARE PLANNING
☐5 WISHES PACKET GIVEN
☐HOSPICE MODEL OF CARE DISCUSSED

Patient Name: _____Patient DOB: _____

DEPRESSION SCREENING – PHQ9

Over the last two weeks, how often have you experienced the following:

	NEVER	SOMETI	HALF THE TIME	DAILY
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite	**0**	**1**	**2**	**3**
Feeling bad about yourself, feeling like a failure who let yourself down	**0**	**1**	**2**	**3**
Trouble concentrating on things such as reading or watching television	**0**	**1**	**2**	**3**
Moving or speaking more slowly or fidgeting/restless so that other People have noticed a change in your behavior	**0**	**1**	**2**	**3**
Thoughts of hurting yourself, or feeling you would be better off dead	**0**	**1**	**2**	**3**

TOTAL SCORE _____

☐G0444 Annual Depression Screening

☐G8431 Positive Depression Screening with Documented Follow up plan

☐G8510 Negative Depression Screening

☐G9717 Exclusion for Known DX of Depression

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

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Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD ® is a trademark of Pfizer Inc.

Reference
Spitzer, R. L., Kroenke, K., Williams, J. B. W., Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166*(10), 1092-1097.

Patient Name: _____Patient DOB: _____

Date of last AWV: _____

TO BE COMPLETED BY MEDICAL ASSISTANT

MEDICATION REVIEW (attach copy of printed medication list)

I HAVE REVIEWED AND UPDATED THE ATTACHED MEDICATION LIST ☐

☐G8427 Medication Reconciliation

BLOOD PRESSURE and BMI ASSESSMENT

Blood Pressure _____ BMI _____

Plan _____

_____

☐G8476 BP <140/90
☐G8420 BMI within normal limits (23-30)
☐G8418 BMI <23
☐G8417 BMI >30
☐G0447 Behavioral counseling for obesity

TIMED SIT/STAND/WALK – *Greater than 12 seconds is considered high risk*

_____ seconds to walk 3 meters from sitting to standing position. Greater than 12 seconds is considered high risk for falling.

☐1101F NO FUTURE RISK OF FALLING
☐1100F PATIENT HAS HAD 2 OR MORE FALLS WITHIN THE PAST YEAR
☐3288F RISK ASSESSMENT WITH CHART DOCUMENTATION (ORTHOSTATICS, VISION, HOME FALL HAZARDS, MEDICATIONS)

COGNITIVE FUNCTION SCREENING

	Correct	1 Error	>1 Error
What year is it?	0	4	-
What month is it?	0	3	-
Ask patient to remember the following address: **Ann Black** **37 East Street** **Wheaton** Make sure patient can repeat address properly and inform him/her that you will ask for it later.	-	-	-
What time is it?	0	3	-
Count backwards from 20 to 1	0	2	4
Recite months of the year backwards	0	2	4
Ask patient to repeat the address given above	0	3	

2 Errors	3 Errors	4 Errors	All Incorrect
4	6	8	10

TOTAL SCORE: _____

SCORING: 0-7 Normal – 8-9 Mild Cognitive Impairment (Order Memory Screening) – 10-28 Significant Cognitive Impairment (refer)

PREVENTATIVE SCREENING

Type of Screening	*Date of Screening*	*Location of Screening*
Colonoscopy ☐ 3017F Exclusion for colorectal cancer ☐ Z85.038		
Cologuard		
FOBT		
Mammogram ☐ 3014F Exclusion due to BIL mastectomy ☐ Z90.13		
DEXA (Bone Density)		
PAP ☐G0101		
PSA & digital rectal exam ☐G0102		
ECHO (for patients with heart issues)		
CT cancer screening (for patients with significant smoking hx)		
Diabetic foot exam ☐ 2028F		
Diabetic eye exam ☐ 2022F Results negative for retinopathy ☐ 2023F		
PFT (Spirometry) (for patients with COPD)		
NIOX (for patients with asthma)		
Cognitive Testing (for patients with memory concerns)		
Patient Specific Testing		
Patient Specific Testing		
Patient Specific Testing		

IMMUNIZATIONS

Vaccine	***Date(s) Given***	***Where Given***
Flu		
Pneumonia PPSV23		
Pneumonia PCV13		
Pneumonia PCV15		
Pneumonia PCV20		
Tdap (Tetanus)		
Shingles		
RSV		
COVID-19 (last date received)		

☐4040F PNEUMONIA VACCINE ADMINISTERED OR PREVIOUSLY RECEIVED

☐G8482 FLU VACCINE ADMINISTERED OR PREVIOUSLY RECEIVED

☐G8483 FLU VACCINE NOT RECEIVED FOR MEDICAL/PERSONAL REASON

TO BE COMPLETED BY PROVIDER

☐Reviewed chronic conditions and may consider:

Pt is currently on statin - ☐4013F or ☐G9781 if not prescribed for medical reason

CAD with prior MI or HF (LVEF <40%) requires beta blocker - ☐4008F

CKD (stage 4 or 5, not RRT) and HTN and proteinuria requires ACE/ARB - ☐4010F

Last HgA1c was <7 ☐3044F >7 to <8 ☐3051F ☐>8 to <9 3052F >9 ☐3046F

Ischemic Vascular Disease requires anti-platelet therapy - ☐4011F<

☐Patient meets CCM eligibility with 2 or more chronic conditions and will refer to CCM Coordinator

Frailty ☐ G2099 & must include 2 of the following dx codes in visit note:

☐ Abnormality of gait ☐ History of Fall ☐ Debility ☐ Abnormal Weight Loss ☐ BMI <19 ☐ Pressure Ulcer

☐ Muscle Weakness ☐ Severe Morbid Obesity ☐ Use of DME (must specify) ☐ Unsteadiness of Feet

☐ Protein Calorie Malnutrition ☐ Senile Degeneration of Brain

Medicare Advantage plan physical exam included – ☐99397 (or appropriate code if under 65)

Updated 7/29/26