**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**

[x] 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 COUNSELING 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:*

[ ] >15 MIN AND <44 MINUTES SPENT

[ ]  Advanced Directives

[ ]  Living Will

[ ]  DNR

My surrogate decision maker is:

*Name Phone Relationship*

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |

[ ] 99497 ADVANCE CARE PLANNING

[ ] 5 WISHES PACKET GIVEN

[ ] HOSPICE MODEL OF CARE DISCUSSED

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEPRESSION SCREENING – PHQ9**

Over the last wo 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 otherPeople 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

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* [ ]

 **pp**

[x] 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/he 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 TOTAL SCORE: \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| 4 | 6 | 8 | 10 |

**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 11/18/24**