**ANNUAL WELLNESS VISIT – HEALTH RISK ASSESSMENT**

**DATE OF 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 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 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

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

**TO BE COMPLETED BY MEDICAL ASSISTANT**

**MEDICATION REVIEW (attach copy of printed medication list)**

*I HAVE REVIEWED AND UPDATED THE ATTACHED MEDICATION LIST*

**pp**

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**

**Use Chart**

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

Patient is frail with one or more diagnosis of abnormality of gait, debility, failure to thrive, feeding difficulties, cachexia, malnutrition, protein calorie malnutrition, severe morbid obesity, muscle wasting, atrophy/weakness, pressure ulcer, senile degeneration of brain? Conditions should be coded in visit note.

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

Updated 10/9/23