Medicare Well Patient Visits

Gender: M F	____IPPE Welcome to Medicare (G0402) 1 time during first 12 months of coverage	_____Initial AWV (G0438) 1 in a lifetime after coverage for 1 year	____Subsequent AWV (G0439) each year after initial visit

FULL NAME_____ Birthdate_____ Today's Date_____ Office Use (MRN)_____

List any allergies_____

List any medications you take, including over the counter

NAME	DOSE	HOW OFTEN TAKEN		NAME	DOSE	HOW OFTEN TAKEN

List all doctors/ pharmacies/ medical supply companies you have used within the past year:

NAME	**SPECIALTY**	**PHONE NUMBER**

Have you ever been diagnosed with any of the following?

	YES	NO			YES	NO			YES	NO
Diabetes				Asthma				Arthritis		
Hypertension				Emphysema/ COPD				Osteoporosis		
Heart Disease				Heart Burn/ GERD				Gout		
Heart Murmur				Hepatitis				Kidney Disease		
Peripheral Artery Disease				Diverticulosis				Glaucoma		
Rheumatic Fever				Anemia				Restless Leg Syndrome		
Stroke				Bleeding Disorders				Peripheral Neuropathy		
High Cholesterol				Cancer				Mental Health Problems		
Sleep Apnea				Thyroid problems				Other Health Problems		

List any surgeries you have had

Type	Date	Doctor's Name		Type	Date	Doctor's Name

List any major injuries you have had

Type	Date	Doctor's Name		Type	Date	Doctor's Name

List any hospitalizations you have had that are not listed above

Type	Date	Doctor's Name		Type	Date	Doctor's Name

Has anyone in your family been diagnosed with

	Yes	No	Parent	Grandparent	Sibling	Children
Heart Disease						
Hypertension						
Stroke						
Cancer						
Diabetes						
Thyroid						
Osteoporosis						
Glaucoma						
Mental Illness						

Health Habits

Tobacco	Yes	No	Past	Daily Amount	Years of Use	When Stopped		Alcohol	Yes	No	Past	Daily Amount	Years of Use	When Stopped
Smoke								Beer						
Dip								Wine						
Chew								Liquor						
Drugs														

If you answered yes to Drug use:

Type of Drugs_____ Have you ever misused prescription drugs? ____Yes ____No

Would you be interested in quitting tobacco/ alcohol/ drug use within the next month? _____Yes _____No

When was your last

Screenings	Date	Screenings	Date	Vaccines	Date	Vaccines	Date	Vaccines	Date
Pap Smear		Colonoscopy		Flu		Pneumonia		Meningitis	
Mammogram		Prostate Exam		Hepatitis		Polio		Yellow Fever	
Bone Density		Eye Exam		Tetanus		Measles/Mumps/Rubella		Other Vaccine	

General Health

In general, would you say your health is

❒ Excellent ❒ Very Good ❒ Good ❒ Fair ❒ Poor

Sleep

Each night, how many hours of sleep do you usually get? ____ hours

Do you snore or has anyone told you that you snore? ❒ Yes ❒ No

In the past 7 days, how often have you felt sleepy during the daytime?

❒ Almost all of the time ❒ Some of the time ❒ Most of the time ❒ Almost never

Depression PHQ-9

In the past two weeks, how often have you been bothered by any of the following problems? Place a check mark over your answer	Not at all	Several Days	More than half of the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Felt down, depressed, or hopeless?	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	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
SCORE (for office use)				
TOTAL SCORE (for office use)				
10. 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?	**Not difficult at all**	**Somewhat Difficult**	**Very difficult**	**Extremely difficult**

Anxiety

During the past 2 weeks, how often have you felt nervous, anxious, or on edge?

❒ Almost all of the time ❒ Some of the time ❒ Most of the time ❒Almost never

During the past 2 weeks, how often were you not able to stop worrying or control your worrying?

❒ Almost all of the time ❒ Some of the time ❒ Most of the time ❒Almost never

Stress

How often is stress a problem for you in handling such things as your health, finances, family or social relationships or work?

❒ Almost all of the time ❒ Some of the time ❒ Most of the time ❒Almost never

Support

In the past 4 weeks, was someone available to help you if you needed or wanted help? (For example, if you felt nervous, lonely, or blue; got sick and needed help; needed someone to talk to, needed help with daily chores or just taking care of yourself?

❒ Almost all of the time ❒ Some of the time ❒ Most of the time ❒Almost never

Pain

During the past 4 weeks, how much bodily pain have you generally had?

❒ No pain ❒Mild Pain ❒Moderate Pain ❒Severe Pain

Functional Ability and Level of Safety

Hearing Impairment

Do you have difficulty hearing normal conversations? ❒ Yes ❒ No

Do your family members or friends complain that you are hard of hearing? ❒ Yes ❒ No

Instrumental Activities of Daily Living

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?

❒ Yes ❒ No

In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, managing money, using the telephone, preparing meals, transportation, or taking your own medications?

❒ Yes ❒ No

Physical Activity
In the past 2 weeks, how many days did you exercise for 20 minutes or more? _____days

How intense was your typical exercise?
❒ Light (like stretching or slow walking) ❒ Moderate (like brisk walking)
❒ Heavy (like jogging or swimming) ❒ Very heavy (like fast running or stair climbing)
❒ I am currently not exercising

Home Safety

Do you live in _____private home ____assisted living facility ____other

Do you have working smoke detectors in your home? _____Yes ____No

Do you have working fire extinguishers in your home? ____Yes ____No

Do you have a working carbon monoxide detector in your home? ____Yes ____No

Does your home have rugs on the floor, lack grab bars in the bathroom, lack handles on the stairs, or have poor lighting?
_____Yes ___No

Has anyone tried to cause you physical harm within the last two months? ____Yes ___No

Nutrition
How many servings of fruits and vegetables do you typically eat each day? _____ servings per day

How many servings of high fiber or whole grain foods do you typically eat each day? _____ servings per day

How many servings of fried or high-fat foods do you typically eat each day? _____ servings per day

How many sugar-sweetened (not diet) beverages did you typically consume each day? _____servings per day

Advanced Directives
Do you currently have a Living Will? ❒ Yes ❒ No
Do you currently have a Durable Health Care Power of Attorney? ❒ Yes ❒ No
If you answered no, are you interested in obtaining further information about Living Wills or Durable Health Care Power of Attorney? ❒ Yes ❒ No

Are there any other health concerns you have at this time? _____

Patient Signature_____ **Date**_____

PATIENT, PLEASE STOP HERE

Patient's Name: _____ DOB: _____

MRN: _____

Physical Exam: Height_____ Weight_____ BMI_____ BP Left_____ BP Right_____

Visual Acuity: Uncorrected Right_____ Left_____ Both_____ Corrected Right_____ Left_____ Both_____

Mini Cog Step 1: Three Word Registration: Look directly at person and say, "Please listen carefully, I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step2 (clock drawing).

The following and other word lists have been used in one or more clinical studies. 1-3 For repeated administrations, use of an alternate word listing is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing: Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall: Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version: _____ Person's Answers: _____ _____ _____

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12,3,6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

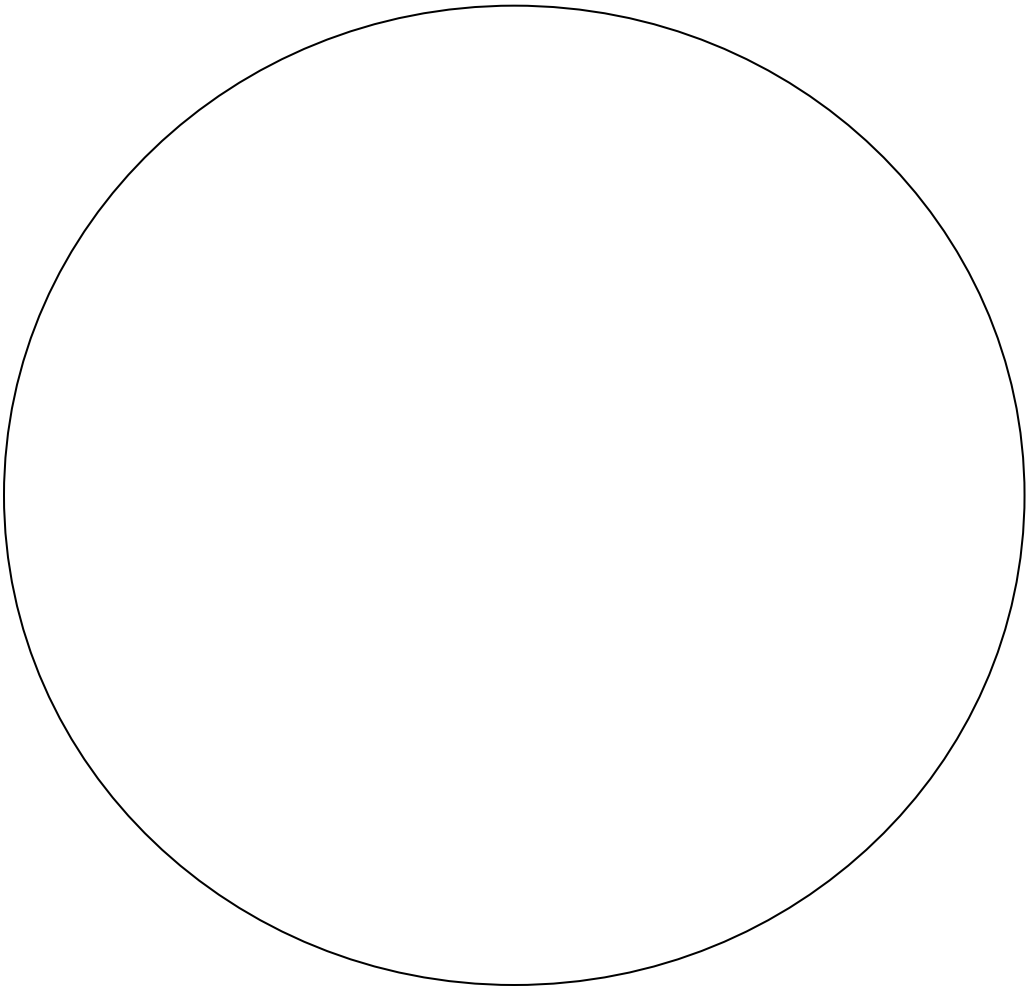
Other physical exam factors deemed appropriate based on patient's medical and social history and current clinical standards:

Provider Signature_____ Date_____

Patient's Name: _____ Date: _____

DOB: _____ MRN: _____

Time: _____



INTENSIVE BEHAVIORAL THERAPY FOR CARDIOVASCULAR DISEASE

Patient was counseled on the use of aspirin, tobacco cessation, importance of exercise, health diet and BMI goals. We also discussed the importance of controlling cholesterol abnormalities.

The following handouts were reviewed with and provided to the patient:

1. Healthy Eating Plate Form
2. Heart Disease Form
3. Tobacco Cessation Form

Total Time Spent with patient was _____ min. (must be 15 minutes to bill)

Provider's Signature: _____ Date: _____

Patient's Name: _____ Date: _____ Time: _____ AM/PM

DOB: _____ MRN: _____

Have you ever had a fall with injury YES NO If yes, how many_____?

[ ] Coordination and gait within normal limits

THE TIMED UP AND GO (TUG) TEST

PURPOSE: To assess mobility
EQUIPMENT: A stopwatch
DIRECTIONS: Patients wear their regular footwear and can use a walking aid if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters or 10 feet away on the floor.

INSTRUCTIONS TO PATIENT:

When I say "Go," I want you to:

1. Stand up from the chair
2. Walk to the line on the floor at your normal pace
3. Turn
4. Walk back to the chair at your normal pace
5. Sit down again

On the word "Go" begin timing

Stop timing after patient has sat back down and record. **TIME**: _____ seconds

An older adult who takes > or = to 12 seconds to complete the TUG is at high risk for falling.

Observe the patient's postural stability, gait, stride length, and sway.

Circle all that apply:

Slow tentative pace	Little or no arm swing
Loss of balance	Steadying self on walls
Short strides	Shuffling
En block turning	Not using assistive device properly

NOTES:

CAGE SUBSTANCE ABUSE SCREENING TOOL

Directions: Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

CAGE Questions:

Total Time Spent with patient was _____ min. (must be 15 minutes to bill)

1. Have you ever felt you should **cut** down on your drinking?
2. Have people **annoyed** you by criticizing your drinking?
3. Have you ever felt bad or **guilty** about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**Eye**-opener)?

SCORING: 0 for "no" and 1 for "yes." A total score of 2 or greater is considered clinically significant.

Provider Signature_____ Date_____

PATIENT NAME_____ **DOB:** _____ **MRN:** _____

COUNSELING AND REFERRALS FOR OTHER PREVENTATIVE SERVICES			**5 TO 10 YEAR PLAN OF CARE**	
	Preventative Service	Received	Recommendation	Scheduled
Vaccines	• Pneumococcal			
	• Prevnar			
	• Influenza			
	• Hepatitis			
	• Zoster			
	• TDaP			
Mammogram	• Annually			
Pap and Pelvic Examination	• Annually if high risk or with an abnormal PAP within the past 3 years • Every 24 months for other women			
Prostate Cancer Screening	• DRE and PSA - Males age 50 or older. (Consider stopping if >70 years of age)			
Colorectal Screening	• FOBT annually • Screening Colonoscopy every 10 years or every 2 years for high risk			
Diabetes	• Up to 10 hours of initial self-management training within a continuous 12-month period • Subsequent years: Up to 2 hours of follow-up training each year after the initial year • Foot exam yearly • Diabetes Screening (FSBS or GTT)			
Dilated Eye Exam	• Dilated eye exam yearly (refer to Ophthalmology			
Medical Nutrition Therapy (by RD)	For DM, CKD, S/P Renal transplant within last 3 years • First year: 3 hours of one-on-one counseling OR, Subsequent years: 2 hours			
Bone Mass Measurement (65 and older, biennial)	• Women determined to be estrogen deficient and at clinical risk for osteoporosis • Individuals with vertebral abnormalities, receiving or expected to receive glucocorticoid therapy for more than 3 months, with primary hyperparathyroidism, being monitored to assess response to FDA-approved osteoporosis drug therapy			
Glaucoma Screening	• Patients with diabetes mellitus, family history of glaucoma, African Americans aged 50 or older • Hispanic Americans aged 65 or older			
Cardiovascular Screening	• Lipids every 5 years • Screening EKG optional and is allowed only once in a lifetime during the IPPE • US for AAA- one time only at time of IPPE			
HIV Screening	• Annually if high risk			
Hepatitis C Screening	• Annually for continued IV drug use since previous negative test • Once in a lifetime for those born between 1945 and 1965, not high risk			
Tobacco Cessation Counseling	• Two cessation attempts per year; each attempt includes a maximum of four intermediate or intensive sessions, up to eight sessions in a 12-month period [ ] We spent greater than 3-minutes discussing the importance of tobacco cessation. We discussed options such as OTC and prescription Rx. The patient was also given information on the stop tobacco smoking line for Georgia.			
Advanced Directives	• Patient has executed an Advanced Directive • If no, patient was given an opportunity to discuss and execute Advanced Directive • Provider assisted patient with completion of Advanced Directive • Provider is willing to follow the patient's wishes as expressed in Advanced Directive [ ] We spent 16-30 minutes with the patient discussing the importance of Advance Care Planning. We discussed power of attorney, living will, and DNR options. We reviewed the Georgia Advance Directive for Health Care form and the patient was encouraged to complete and return. All questions were answered.		_____Yes _____Yes _____Yes _____Yes	____No ____No ____No ____No
	PROVIDER'S SIGNATURE			**DATE**