Patient Name_____ Initial Exam (G0438) Subsequent Year Exam (G0439)

Springhill Medical Group—**Medicare Annual Wellness Exam** **Date:** _____ **DOB:** _____ **Sex at Birth:** _____

ALLERGIES (Drug or Food): _____

Other Doctors/Providers I see: Dr./NP _____ Specialty_____ For my: _____

Dr./NP _____ Specialty_____ For my: _____

Last Eye Exam_____ Last Dental Exam_____ Last Hearing Exam _____ Still Driving? ◯ no ◯ **yes**

MEDICATION SAFETY	
Where do you store your medications?	
Do you have a pill organizer?	◯ yes ◯ **no**
Do you keep a medication list in your wallet or purse at all times?	◯ yes ◯ **no**
NICOTINE	
Are you a Current Smoker? **Packs/Day**_____	◯ no ◯ **yes**
History of Smoking? **Quit Date** _____	◯ no ◯ **yes**
Have you ever been exposed to second-hand smoke?	◯ no ◯ **yes**
ALCOHOL	
Do you drink beer/wine or liquor? (if no, skip to next section)	◯ no ◯ **yes**
Do you drink alcohol every week?	◯ no ◯ **yes**
How many alcohol drinks per day? ◯ 0 ◯ 1-2 ◯ 2-3 ◯ 3-4 ◯ **5-6** ◯ **7 or >**	
How often do you have more than 4 or 5 drinks on one occasion? ◯ never ◯ **monthly** ◯ **weekly** ◯ **daily**	
CAFFEINE	
Do you drink caffeinated beverages? (if no, skip to next section)	◯ no ◯ **yes**
◯ **coffee** ◯ **teas** ◯ **colas/sodas** How many cups /day _____	
DRUGS/ PRESCRIPTION DRUGS	
Have you ever used street drugs?	◯ no ◯ **yes**
What drug(s): How often? **Quit Date**:_____	
Have you ever used injectable drugs?	◯ no ◯ **yes**
Do you use any street drugs now?	◯ no ◯ **yes**
What drug(s): **How often?**	
Have you used prescription drugs for non-medical reasons?	◯ no ◯ **yes**
DEPRESSION (PHQ-2)	
Over the last TWO weeks have you lost interest or pleasure in doing things? ◯ Not at all ◯ **Several days** ◯ **>half the days** ◯ **nearly every day**	
Over the last TWO weeks have you felt down, depressed or hopeless? ◯ Not at all ◯ **Several days** ◯ **>half the days** ◯ **nearly every day**	
HIV EXPOSURE	
Are you sexually active?	◯ no ◯ **yes**
Using protection against sexually transmitted infections?	◯ yes ◯ **no**
EXPOSURE TO VIOLENCE	
Do you feel safe in your home?	◯ yes ◯ **no**
Has anyone threatened your physical wellbeing?	◯no ◯ **yes**
Are you worried someone is stealing your money?	◯no ◯ **yes**
HEARING	
Have you had trouble with your hearing?	◯ no ◯ **yes**
Difficulty hearing the TV or Radio?	◯ no ◯ **yes**
Difficulty hearing callers on the Telephone?	◯ no ◯ **yes**

Provider Comments

Patient Name_____Initial Exam (G0438) Subsequent Year Exam (G0439)

VISION	
Have you had trouble with your vision?	◯ no ◯ **yes**
Is it difficult to see at night?	◯ no ◯ **yes**
Are your eyes dry, more than normal?	◯ no ◯ **yes**
NUTRITION	
Are you easily able to obtain healthy food?	◯ yes ◯ **no**
Do you often eat too much food?	◯ no ◯ **yes**
Are you eating less food to save money?	◯ no ◯ **yes**
Do you have difficulty chewing or swallowing food or liquids	◯ no ◯ **yes**
Dentures/partials? _____ Are they fitting well?	◯ yes ◯ **no**
DRIVING & HOME SAFETY	
Do you always wear your seatbelt when you drive?	◯ yes ◯ **no**
Are you family or friends concerned about your driving?	◯ no ◯ **yes**
Have you fallen 2 or more times in the past year?	◯ no ◯ **yes**
Are there tripping hazards in your home? (throw rugs, loose cords)	◯ no ◯ **yes**
Is your home Clutter free?	◯ yes ◯ **no**
Are non-slip mats in all tubs/showers	◯ yes ◯ **no**
Have you ever been injured from a fall?	◯ no ◯ **yes**
Are you afraid of falling?	◯ no ◯ **yes**
Are Emergency Phone Numbers kept by the phone and updated	◯ yes ◯ **no**
Any firearms in the home?	◯ no ◯ **yes**
Stored safely and unloaded?	◯ yes ◯ **no**
Do you have someone to call in case of an emergency	◯ yes ◯ **no**
Do you have someone assist you with decisions about health care?	◯ yes ◯ **no**
Do you have an advanced care directive or a POLST?	◯ yes ◯ **no**

Provider Comments

ACTIVITIES OF DAILY LIVING
Do you need assistance to bath or shower? ◯ no ◯ **yes**
Do you need assistance to dress or undress in the morning or evening? ◯ no ◯ **yes**
Do you need assistance to use the toilet? ◯ no ◯ **yes**
Do you sometimes leak urine? ◯ no ◯ **yes**
Do you sometimes leak stool? ◯ no ◯ **yes**
Any difficulty walking? ◯ no ◯ **yes**
Are you able to walk several blocks? ◯ yes ◯ **no**
Can you pull or push large objects? ◯ yes ◯ **no**
Are you able to pay your bills by yourself? ◯ yes ◯ **no**

COGNITIVE ABILITY
Are you having any sleeping problems? ◯ no ◯ **yes**
Have you had trouble feeling alert in the day? ◯ no ◯ **yes**
Any difficulty expressing your thoughts? ◯ no ◯ **yes**
Any trouble remembering words or names? ◯ no ◯ **yes**
Any trouble focusing on one thing at a time? ◯ no ◯ **yes**
Are you misplacing things more frequently ◯ no ◯ **yes**
Do you feel easily distractible? ◯ no ◯ **yes**
Are your worried your memory is changing? ◯ no ◯ **yes**
Has a family member or friend told you that you're not remembering things the way you have before? ◯ no ◯ **yes**
Are tasks that were once easy for you becoming a greater challenge (paying taxes or bills)? ◯ no ◯ **yes**

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↓ Completed With Medical Assistant/RN ↓

◯ **MEDICATION RECONCILIATION** completed by RN in Electronic Health Record: _____ **(Initials)**

Get Up & Go Test				
Pass	Pass >10sec	Fail	1. Ask Patient to stand from chair, walk several paces, turn, and return to the chair 2. Assistive devices are permitted 3. Patient passes test if able to walk without difficulty and is stable on their feet. **Fallen in the last 12 months?** ◯ None ◯ Once ◯ Twice ◯ Three or more **Use any devices?** ◯ Cane ◯ Walker ◯ Wheelchair ◯ None	◯ **Refer for difficulty walking and fall prevention**

Cognitive Test (+ / -)		
What year is this?	Correct	Incorrect
What month is this?	Correct	Incorrect
What is the day of the week?	Correct	Incorrect

1. Read the following to the patient **"I would like to ask you some questions that ask you to use your memory. I am going to name three objects. Please wait until I saw all three words, and then repeat them. Remember what they are because I am going to ask you to name them again in a few minutes".**
   "Please repeat these words for me: APPLE – TABLE – PENNY"
2. Interviewer may repeat the words 3 times if necessary before asking questions. Patient should be able to repeat the words to continue the test.
3. Ask the questions below and record each answer as either correct or incorrect.

Results: ◯ **Pass** (4-6 answers correct) ◯ **Fail** (3 or Less Correct Answers)

Recall the Three objects I asked?	Apple	Table	Penny		◯ **Refer for Cognitive Evaluation**

↓ Completed With Primary Care Provider ↓

Vaccines	Date Last	Order today
Influenza (Annual)		
Pneumococcal (Once)		
Prevnar 13 (Once)		
Tetanus Only (Not covered by Medicare)		
TDAP (Every 10 years) (Not covered by Medicare)		
Zostavax (Once)		
Shingrix **NEW!** (2 shots 2-6 months apart)		
Hepatitis B (covered for high risk only)		

Laboratory Screening		
Lipid Panel annually		
Glucose / HgA1C% (DM = Q3 months)		
PSA **V76.4** (men only) (♂ by USPSTF guideline)		
HCV antibody G0472 (♀/♂ by USPSTF guideline)		

Diagnostic Screening	Date Last Vaccine	Order today
Bone Density (♀ Every 2 years)		
Mammogram **V76.10** (Annual ♀ > 40)		
PAP ♀ (Q5 yrs up to age 64 Continue screen if hx of abnl)		
Colonoscopy **V76.51** (Every 10yrs; high risk 3-5 yrs)		
Abd U/S AAA **CPT G0389** (Once for Men with +Smoking Hx **V15.32** or CV disease **V17.4**		
Lung Cancer Screening Current smoker or quit < 15yo		
Eye Exam (Annual)		

Medical Referrals	
Hearing (ENT or Audiology)	
Neurology (Cognitive Evaluation)	
Dental Care	
Podiatry: Diabetic Foot Care	
◯ Refer to Chronic Care Management	
◯ Medications Reviewed with Patient	

Health Risk Assessment	
DEPRESSION	
Medications Ordered	
F/U with MD/ Edu Literature Given	
Community Resources Provided	
Mental health Referral Complete	
ALCOHOL RISK	
ETOH-Treatment Referral	
ETOH-Community Resource	
ETOH-Education Provided	
NICOTINE RISK	
Nicotine-Treatment Referral	
Nicotine-Community Resource	
Nicotine-Education Provided	
FALL RISK	
Fall Risk Assessment	
PT/OT Referral	
HH Evaluation	
Fall Prevention Information Given	
NUTRITION & OBESITY RISK	
Referral to Nutritionist	
Counseling Provided	
Community Resources Given	
HOME/LIFE SAFETY RISK	
Mature Driver's Course Referral	
Elder abuse Information provided	
Mandatory Reporting Complete	

Signed by MD/NP: _____

Date: _____ Follow up in _____ Months