A Northside Network Provider

English - Spanish

Patient's name: ______________________________ **Date of Birth:** ______________

Medicare B enrollment date: ______________ *

Today's date: ______________

Health Risk Assessment has been reviewed by physicians, signed and dated: Initial ______

MEDICAL/SOCIAL HISTORY

Past personal illnesses or injuries:

Injury/Illness/Surgery	Date	Hospitalized? (Indicate Yes or No)

Medications, supplements and vitamins:

Drug allergies/other allergies:

Social history notes (including diet, physical activities, alcohol use, drug use and tobacco use):

Family history notes:

	Mother	Father	Brother	Sister	Son	Daughter
Deceased						
Hypertension						
Stroke						
Diabetes						
Kidney disease						
Heart disease						
Cancer						
Other						

Other physicians and providers/suppliers of care (include provider name, specialty & type of care)

**WELCOME TO MEDICARE
IPPE/ANNUAL WELLNESS VISIT**

DEPRESSION SCREEN**

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Further evaluation is required if the patient answers anything other than **Not at All** on Depression Screen. **Use form: Depression Screening PHQ-9 (PP0012)**

ALCOHOL/DRUG SCREEN**

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

MEN: How many times in the past year have you had 5 or more drinks in a day? None __ 1 or more __

WOMEN: How many times in the past year have you had 4 or more drinks in a day? None __ 1 or more __

TO BE COMPLETED WITH THE PROVIDER

Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons? None __ 1 or more __

Further evaluation is required if the patient answers **1 or more** on the Alcohol/Drug Screen.* **Use form: Alcohol Screening AUDIT (PP1083) or Drug Screening DAST (PP1082)**

PHYSICAL EXAMINATION

Height: __________ Weight: __________

Blood Pressure: __________ BMI: __________

Visual Acuity **(IPPE only)**:

	With Correction	Without correction
L		
R		
Both		

FUNCTIONAL ABILITY/SAFETY SCREEN**

1. Was the patient's timed Up & Go test unsteady or long than 30 seconds? ☐ Yes ☐ No
2. Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? ☐ Yes ☐ No
3. Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting? ☐ Yes ☐ No
4. Have you noticed any hearing difficulties? ☐ Yes ☐ No

Further evaluation is required if the patient answers **Yes** on Functional Ability/Safety Screen.* **Use form: Fall Prevention Checklist (PP0011)**

EVALUATION OF COGNITIVE FUNCTION

Complete the 2-page Mini-Cog Form

Mood/Affect: ____________________

Appearance: ____________________

Family member/Caregiver input: ____________________

ELECTROCARDIOGRAM (G0403-EKG) – Only at the time of the IPPE

Referral or result: ____________________

EVALUATIONS/REFERRALS BASED ON HISTORY, EXAM AND SCREENING:

DISCUSSION OF ADVANCE DIRECTIVE (PATIENT PREFERENCE, PHYSICIAN AGREEMENT/DISAGREEMENT-if patient consents):

☐ **Reviewed medical and family history for opioid use and if applicable, patient was assessed for non-opioid pain therapy replacement.**

Physician's signature: ____________________ **Date:** __________ **Time:** __________

A Northside Network Provider

(must be viewed by physician, signed and dated)

English - Spanish

Patient's name: ______________________________ **Date of Birth:** ______________

Medicare B eligibility date: ____________________ **Today's date:** ______________________

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

1. Have you fallen in the past year? ☐ Yes ☐ No
2. Are you worried you might fall? ☐ Yes ☐ No
3. Do you use a cane or walker? ☐ Yes ☐ No
4. Do you need someone to help you get up in the morning? ☐ Yes ☐ No
5. In the past four weeks, have you fallen or felt dizzy when standing up? ☐ Yes ☐ No
6. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around in the house? ☐ Yes ☐ No
7. Do you have trouble consistently taking or remembering to take all of your medications as prescribed?
   ☐ Yes ☐ No ☐ N/A
8. During the past four weeks, have you had pain present?
   ☐ Yes ☐ No
   ☐ Primary Pain Location____________ ☐ Numeric Rating Scale (0-No pain - 10-Worst pain)______
9. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?) ☐ Yes ☐ No
10. Can you go shopping for groceries or clothes without someone's help? ☐ Yes ☐ No
11. Can you prepare your own meals? ☐ Yes ☐ No
12. Can you do your housework without help? ☐ Yes ☐ No
13. Can you handle your own money without help? ☐ Yes ☐ No
14. How have things been going for you during the past four weeks?
    ☐ Very well, could hardly be better ☐ Pretty bad
    ☐ Pretty well ☐ Very bad; could hardly be worse
    ☐ Good and bad parts, about equal
15. During the past four weeks, how would you rate your health in general?
    ☐ Excellent ☐ Fair
    ☐ Very good ☐ Poor
    ☐ Good
16. During the past four weeks, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)
    ☐ Yes, as much as I wanted ☐ Yes, a little
    ☐ Yes, quite a bit ☐ No, not at all
    ☐ Yes, some

Reorder #65004 PP0429 MEDICARE PACKET

17. During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

18. How often during the past four weeks have you been *bothered* by any of the following problems?
   Please indicate with: Never, Seldom, Sometimes, Often or Always
   Sexual problems ______________________
   Trouble eating well ______________________
   Teeth or denture problems ______________________
   Problems using the telephone ______________________

19. How confident are you that you can control and manage most of your health problems?
   - ☐ Very confident
   - ☐ Somewhat confident
   - ☐ Not very confident
   - ☐ I do not have any health problems

20. Are you having difficulties driving your car?
   - ☐ Yes, often
   - ☐ Sometimes
   - ☐ No
   - ☐ Not applicable, I do not use a car

21. Do you always fasten your seat belt when you are in a car?
   - ☐ I always fasten my seat belt
   - ☐ I occasionally fasten my seat belt
   - ☐ I never fasten my seat belt

22. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?
   - ☐ Very heavy
   - ☐ Heavy
   - ☐ Moderate
   - ☐ Light
   - ☐ Very light

23. Do you exercise for about 20 minutes three or more days a week?
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ No, I usually do not exercise this much

24. Have you been given any information to help you with the following:
   Hazards in your house that might hurt you? ☐ Yes ☐ No
   Keeping track of your medications? ☐ Yes ☐ No

25. How often do you have trouble taking medicines the way you have been told to take them?
   - ☐ I do not have to take medicine
   - ☐ I always take them as prescribed
   - ☐ Sometimes I take them as prescribed
   - ☐ I seldom take them as prescribed

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Provider signature: ______________________ Date: ______________