McLaren Medical Group

Medicare First Annual Wellness Visit

Patient's name: _____ **D.O.B.:** ____/_____/_____

Part B eligibility date: ____/____/_____ **Date of exam:** ____/____/_____

Allergies: _____
_____
_____
_____

Tobacco use: _____
Alcohol use: _____
Drug use: _____
Medications, supplements, vitamins: _____
_____
_____
_____
_____

Medical and social history

Past personal illnesses, injuries, operations	Date	Hospitalized?

Current list of patient's providers and suppliers

Name	Specialty	Reason

Height: _____

Weight: _____

BMI: _____

BP: _____

Visual acuity: L_____ R _____

_____: _____

Family history (check those that apply)

☐ Alcoholism	☐ Cancer	☐ High Cholesterol	☐ Seizures
☐ Anemia, Sickle Cell	☐ Diabetes	☐ Hypertension	☐ Stroke
☐ Arthritis	☐ Heart Disease	☐ Obesity	☐ Thyroid Disease
☐ Bleeding Disorders	☐ Liver Disease	☐ Kidney Disease	☐ Tuberculosis

Notes:

Is the patient on a special diet? Why? _____

Detection of cognitive impairment: _____
_____

Depression screen (ask the following questions, check the response)

1. Over the last two weeks, have you felt down, depressed or hopeless? Yes ☐ No ☐
2. Over the last two weeks, have you felt little interest or pleasure in doing things? Yes ☐ No ☐

Hearing loss screen

1. Do you have trouble hearing the television or radio when others do not? Yes ☐ No ☐
2. Do you have to strain or struggle to hear/understand conversations? Yes ☐ No ☐

Patient Name:

Date of Birth:

Function screen

1. Do you need help with preparing meals, transportation, shopping, taking your medicine, managing your finances, or other activities of daily living? Yes ☐ No ☐
2. Do you live alone? Yes ☐ No ☐

Home safety screen

1. Does your home have throw rugs, poor lighting, or a slippery bathtub/shower? Yes ☐ No ☐
2. Does your home LACK grab bars in bathrooms, handrails on stairs and steps? Yes ☐ No ☐
3. Does your home LACK functioning smoke alarms? Yes ☐ No ☐

Risk for falls screen

1. Was the patient unsteady or take longer than 30 seconds during the timed "get up and go" test? Yes ☐ No ☐

ACTION ITEMS: Information in the patient's history and checking any yes response to the above screening questions should trigger further evaluation(s).		
Evaluation/referral based on screening	**Scheduled appointment (dates, physician, etc.)?**	**Notes**

Advanced care planning

1. Patient Consent: "I consent to discuss end-of-life issues with my healthcare provider."

_____

Patient/Guardian Signature Date

2. Patient already has executed an Advance Directive. Yes ☐ No ☐
3. If no, patient was given an opportunity to execute an Advance Directive today? Yes ☐ No ☐
4. Physician Statement: "This individual has the ability to prepare an Advance Directive." Yes ☐ No ☐
5. Physician has completed a physician order for life-sustaining treatment, or similar document of reflecting the patient's wishes for an advanced care plan. Yes ☐ No ☐
6. Physician is willing to follow the patient's wishes. Yes ☐ No ☐

.

Notes:

Patient Name:

Date of Birth:

Preventive screen (frequency)	Coverage	Previously tested (If yes, when?)	Scheduled for screenings (5 to 10 years)
Bone Mass Measurements (every 24 months)	Medicare patients at risk for developing Osteoporosis		
Cardiovascular Screening Blood Tests (every 5 years) – **Lipid panel** – **Cholesterol** – **Lipoprotein** – **Triglycerides**	All asymptomatic Medicare patients (12-hour fast is required)		
Colorectal Cancer Screening – **Flexible sigmoidoscopy** (4 years, or once every 10 years after a screening colonoscopy – **Screening colonoscopy** (every 24 months at high risk; every 10 years not at high risk) – **Fecal occult blood test** (annually) – **Barium enema** (every 24 months at high risk; every 4 years not at high risk)	– Medicare patients age 50 and up – Screening colonoscopy: Those at high risk; no minimum age – No minimum age for having a barium enema as an alternative to a high risk screening colonoscopy if the patient is at high risk		
Diabetes Screening Tests (2 screening tests per year for patient diagnosed with pre-diabetes; 1 screening per year if previously tested, but not diagnosed with pre-diabetes or if never tested)	Medicare patients with certain risk factors for diabetes or diagnosed with pre-diabetes (patients previously diagnosed with diabetes aren't eligible for benefit)		
Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (Up to 10 hours of initial training within a continuous 12-month period; subsequent years up to 2 hours of follow-up training each year after initial year)	Medicare patients at risk for complications from diabetes, recently diagnosed with diabetes or previously diagnosed with diabetes (must certify DSMT need)		
Glaucoma Screening (annually for patient ins one of the high risk groups)	Patients with diabetes mellitus, family history of glaucoma, African-Americans age 50 and over, or Hispanic-Americans age 65 and up		
Prostate Cancer Screening (annually) – **Digital rectal exam** – **Prostate specific antigen test**	All male patients 50 or older		
Screening Pap Tests and Pelvic Examination (annually if high-risk, or childbearing age with abnormal Pap test within past 3 years; every 24 months for all other women)	All female Medicare patients		
Screening Mammography (annually)	All female patients 40 or older		
Vaccines – **Pneumococcal (once in a lifetime)** – **Seasonal Influenza (once per flu season in the fall or winter)** – **Hepatitis B (scheduled dosages required)**	All Medicare patients – May provide additional pneumococcal vaccinations based on risk and provided that at least 5 years have passed since previous dose – Hepatitis B, if medium/high risk		

Provider signature:_____

Date/Time: _____

Patient Name:

Date of Birth:

EXAM FORM: Completing this form is not required for the Wellness Visit, but is voluntary.

Subjective: C/O:_____ **Referred by:** _____
HPI: □ Well Visit - Last Complete Exam: / / **Current pain:** □ **no** □ **yes** **Severity of Pain:** 0 1 2 3 4 5 6 7 8 9 10 (Circle)

_____
_____
_____

PFSH: □ **See History Form in front of chart dated:** ____/ ____/ _____
Social History: □ **No change** **Tobacco?** □ **Yes** □ **No** **ETOH?** □ **Yes** □ **No** **Drugs?** □ **Yes** □ **No** _____
Family History: □ **No Change** _____
Medical History: □ **No Change** _____

ROS: □ **Constitutional** □ **ENT** □ **Cardiovascular** □ **Respiratory** □ **GI** □ **Musculoskeletal** □ **Skin/Breast**
□ **Neuro** □ **Psych** □ **Endocrine** □ **Hematologic** □ **GU** □ **Allergic/Immunologic** □ **Eyes/Head**

√ = normal X = abnormal other than stated in HPI - explanation
_____
_____
_____

Objective

√ = examined & normal X = abnormal w/ explanation

	Skin		
	Lymph nodes		
	Neck		
	Eyes		
	ENT		
	C/V		
	Abd / Gastro		
	Respiratory		
	Chest / Breasts		
	Back		
	Genitalia		
	Neurologic		
	Psych		
	Extremities / Hips		
	Extremities / upper		

IMP/Dx/Plan:
_____
_____
_____
_____

ORDERS: □ **Oral Meds:** _____ □ **Injection** _____
□ **Rapid Strep**_____ □ **UA** _____ □ **02 Sat**_____ □ **EKG** □ **X-Ray of** _____**- Views:** _____
□ **Lab:** _____ □ **Other:** _____ **done by:** _____

RTO _____ **Days / Weeks / Months / Years / if worsens or no improvement / after tests / PRN** **Educational Material Given:** □ **Yes** □ **No**
Provider names: _____**Time spent with patient** _____ **estimated counseling time** _____ □ **consult**

Provider signature:_____

Date/Time: _____

Patient Name:

Date of Birth: