

McLaren Print System Order

Order No: 57373 Reprint Previous Order No: 5303
Order Date: 2020-10-05
User: Tonya Furtah
Phone: 8105618450

Ship Location: MMG-St. Clair Family Practice - Attn: Tonya
1163 St. Carney Drive
St. Clair, MI 48079

Forms

Quantity: 100
Paragon Dept No: 66000
Dept Name: MMG-St. Clair Family Practice
Company Number: 810

Order Total Price: 16.76

Item Number: MM-56
Item Description: Medicare Annual Wellness Visit
Revision Date: 08/2013
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: Staple (Upper Left)
Drill: None
Misc Info:

McLaren Medical Group
Medicare Annual Wellness Visit

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

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

Medical and social history

Past personal illnesses, injuries, operations	Date	Hospitalized?

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

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)

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia, Sickle Cell	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Obesity	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> 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 lost 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

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Wellness Visit, Family Practice/Internal Medicine Documentation Template
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