

McLaren Print System Order

Order No: 59138 Reprint Previous Order No: 5303
 Order Date: 2020-12-24
 User: Becky Jurish
 Phone: 9898935193

Ship Location: McLaren Bay Internal Medicine East Campus
 714 S Trumbull
 Bay City, Michigan 48708

Forms

Quantity: 100
 Paragon Dept No: 56036
 Dept Name: McLaren Bay Internal Med
 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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