Patient Name: _____ DOB: ____ / ____ / _____ ☐ Male ☐ Female

SENIOR ASSESSMENT FORM

Height:	Weight:	★BMI:	HR:	★ BP Result	___/___/____mm hg
Date of last Flu Vaccine ★	___/___/___		Date of Last BOT (Bone Density Test) Results: _____	___/___/___ T-Score: _____	
Past Medical History:					
Chief Compliant					

Physical Examination

System	WNL	Abnormal	System	WNL	Abnormal
HEENT/Oral			Extremities/Pulses		
Neck			Respiratory		
Integumentary			Neurological		
Gastrointestinal			Psychiatric		
Genitalia/Groin/Buttocks			Hematologic/Lymph		
Back			Musculoskeletal		
Cardiovascular			Allergic/Immunlogic		

Problem/Diagnosis/Assessment

The following section is to be used to provide a current assessment of the patient's active condition(s). Each diagnosis must show that it is being **M**onitored, **E**valuated and **A**ssessed. **T**reatment plan must be provided on the last page. If the form is not complete it will be returned.

☐Yes ☐ No	Cataracts	☐RT ☐LT or ☐Both Eyes ☐**Due to Diabetes** Surgery? ☐Yes ☐No (☐ RT ☐ LT or ☐ Both eyes)	☐Active/Stable ☐Progressive
☐Yes ☐No	★Retinopathy	**Due to Diabetes**? ☐ Yes ☐ No Due to HTN? ☐ Yes ☐ No Date of last Diabetic Eye Exam ___/___/___ ☐ Normal ☐ Positive for Retinopathy Date of last Dilated or Retinal Eye Exam ___/___/___ Results: _____ Eye Provider Name: _____	☐Active/Stable ☐Uncontrolled
☐Yes ☐No	Glaucoma Document name of physician who performed glaucoma screen: _____ _____	☐ **Due to Diabetes**? ☐ Yes ☐ No All patients 65 years and older without a previous history of glaucoma should be screened. (Glaucoma Screen Reporting Requires Tonometry Results.) High-risk patients include: • Diabetes • Family history of glaucoma • African-American >50 years of age • Hispanic-American >65 years of age Screening Date: _____/_____/____ Screening performed by: Optometrist ☐ Ophthalmologist ☐	☐Active/Stable ☐Progressive
Cardiovascular		☐ Chest Pain ☐ Dyspnea ☐ Palpitation ☐ Syncope ☐ Previous MI ☐ Diaphoresis ☐Reynaud's ☐ Claudication ☐Cool Extremities ☐ Cyanosis ☐ Edema ☐ Erythema ☐ Pain in Extremities	
☐ Yes ☐ No	Heart Failure	☐ CHF right or left ventricle failure ☐ Left HF ☐ Systolic HF ☐ Diastolic HF ☐Unspecified HF ☐Combined Sysolic/Diastolic HF Last BNP Result: _____ Last Echo: _____ Ejection Fraction %:_____ Exam Details	☐Active/Stable ☐Progressive ☐Resolved
☐Yes ☐No	CAD/ASHD Old MI	☐Effecting Native Vessel ☐Affecting BP-Graft (type of graft) Exam Details: _____ Date of Event: _____	☐Active/Stable ☐Resolved
☐Yes ☐No	Arrhythmia	Type: Date and Result of Last EKG: Pacemaker Y/N Reason:	☐Active/Stable ☐Uncontrolled ☐Resolved
☐Yes ☐No	Sick Sinus Heart Block Angina	☐Tachycardia-Bradycardia Type: Type:	☐Active/Stable ☐Acute

SENIOR ASSESSMENT FORM

		Exam Details:	☐Uncontrolled ☐Resolved
☐Yes ☐No	HTN	☐ Benign ☐Malignant ☐ Hypertensive Heart Disease ☐with CHF/HF ☐Hypertensive CKD ☐ Hypertensive Heart & CKD _____ Date of LDL-C ___ / ___ / _____ Results_____ Name of provider managing HTN: _____	☐Active/Stable ☐Uncontrolled
☐Yes ☐No	PAD/PVD	☐**Due To Diabetes** or ☐Due to Atherosclerosis or ☐Both Diabetes & Atherosclerosis ☐With Claudication ____ ☐Pain at Rest ___ ☐Ulcers & Location ☐ Gangrene-Location ____ Other:_____ **Date and result of last ABI**:_____ Exam Details:	☐Active/Stable ☐Progressive
☐Yes ☐No	Amputation	Type and Location: _____ Exam Details:	☐Healed ☐Not Healed
☐Yes ☐No	DVT or PE	☐ Acute ☐Chronic ☐History of DVT/PE_____ ☐Greenfield Filter Exam Details:	☐Active/Stable ☐Progressive
☐Yes ☐No	Aneurysm	Location:_____ Size:_____ Last U/S:_____ Exam Details:	☐Active ☐Resolved
Respiratory		☐Cough ☐Dyspnea ☐TB Exposure ☐Hemoptysis ☐ +PPD (Date:_____) ☐Pleuritic Pain ☐Snoring ☐Frequent URIs ☐Wheezing ☐ Sputum Production (Color:_____ Frequency:_____)	
☐Yes ☐No	Lung Disease	☐COPD ☐Emphysema ☐Chronic Bronchitis ☐Asthma ☐Pulmonary HTN ☐Fibrosis of Lung ☐Smoker Cough Date of Last Spirometry : _____ FEV1% (FEV1/FVC): _____ Exam Details:	☐Active/Stable ☐Acute Exacerb ☐End Stage
☐Yes ☐No	Chronic Resp. Failure/Hypoxia	☐Oxygen Dependence ☐Current Tracheotomy Status ☐Reduce Size ☐Hypoxic_____% Oxygen Oxygen Use: ☐Yes ☐No Exam Details:	☐Active/Stable ☐Progressive ☐End Stage
Gastrointestinal		☐Abdominal Mass ☐Abdominal Pain ☐Anorexia ☐Hematemesis ☐Hematochezia ☐Constipation ☐Diarrhea ☐Dysphagia ☐Jaundice ☐Nausea☐Enteral Feeding Tube ★ **Colonoscopy** ☐ Yes ☐ No Date:_____ Details: ★ **Sigmoidoscopy** ☐ Yes ☐ No Date:_____ Details: ★ **FOBT** ☐ Yes ☐ No Date:_____ Details:	
☐Yes ☐No	Cirrhosis	Etiology (if known): Exam Details:	☐Active ☐Resolved
☐Yes ☐No	End Stage Liver Disease	Etiology (if known): Exam Details:	☐Active ☐Resolved
☐Yes ☐No	Hepatitis	Type: ☐A ☐B ☐C ☐Alcoholic ☐Drug Induced ☐Autoimmune ☐Acute ☐Chronic	☐Active/Stable ☐Progressive
☐Yes ☐No	Pancreatic Disease	☐HX of Pancreas Transplant ☐Chronic Pancreatitis Exam Details:	☐Active ☐Resolved
☐Yes ☐No	IBS	Type: ☐Ulcerative Colitis ☐Crohn's Exam Details:	☐Active/Stable ☐Resolved
☐Yes ☐No	CKD	Type: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ End Stage ☐ Unknown **Due to Diabetes**? ☐Yes ☐No On Chronic Dialysis? ☐Yes ☐No Kidney Transplant? ☐Yes ☐No (If yes, which Kidney: ☐ RT ☐ LT) **Date and result of last eGFR**: _____	☐Active/Stable ☐Progressive ☐Resolved

SENIOR ASSESSMENT FORM

Musculoskeletal		☐Ambulation/Gait Changes ☐Back Pain ☐Myalgias ☐Join/bone Symptom ☐Rheumatologic Manifestations	
☐Yes ☐No	Arthritis	Has patient been prescribed drugs to prevent Osteoporosis? Y__N__ Name(s) of Bisphosphonate or Hormone Meds Prescribed: _____ _____ ☐Osteoarthritis ☐Rheumatoid Arthritis Other:_____ Has patient been prescribed Anti Rheumatic Drug? Y__N__ Name(s) of DMARD prescribed: _____ _____	☐Active/Stable ☐Uncontrolled ☐Resolved
Skin/Breast		Skin: ☐Rash ☐Skin Lesion ☐Nail Changes ☐Hair Loss Breast: ☐Nipple Discharge ☐Breast Lumps ☐Breast Pain	
☐Yes ☐No	Skin Ulcer	Type and Location:_____ If Pressure Ulcer: Stage:_____ ☐Gangrene Y☐ N☐ Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
Women Only	Breast Cancer Screening	Date of last Mamogram: ___/____/_____ Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
Neurology		☐Aphasia ☐Dysarthia ☐Focal Weakness ☐Gait Disturbance ☐Headache ☐Incoordination ☐Progressed Cognitive Impairment ☐Incontinence ☐Involuntary Movement ☐Lightheadedness/Dizziness ☐Loss of Consciousness ☐Paresthesias ☐Seizures ☐Tingling to Extremities ☐Tremors ☐Vertigo ☐Numbness, weakness	
☐Yes ☐No	Seizures Multiple Sclerosis	Exam Details: Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
☐Yes ☐No	Parkinsons's Disease	Exam Details :	☐Active/Stable ☐Acute Exacerb
☐Yes ☐No	Neuropathy	**Due to Diabetes**? ☐Yes ☐No ☐Date of last monofilament with result: Location & Etiology: Exam Details:	☐Active/Stable ☐Resolved
☐Yes ☐No	Dementia	Type: ☐Alzheimer's ☐Vascular ☐Senile ☐Last MMSE results if known: ☐Agitation _Delirium ☐ Depressed Mood Exam Details:	☐Early Stage ☐Middle Stage ☐End Stage
Psychology		☐Anger ☐Anxiety ☐Delusions ☐Depression ☐Euphoria ☐Fearfulness ☐Irritability ☐Obsession ☐Paranoia ☐Psychotic Behavior ☐Sleep Disturbance ☐Suicidal Ideations ☐Memory Loss ☐Social Withdraw ☐History of Antipsychotic Drug Use ☐Mood Change ☐Impulsive Behavior ☐Impaired Abstract ☐Personality Change	
☐Yes ☐No	Major Depression	Type: ☐Mild ☐Moderate ☐Severe ☐Partial ☐Full Remission ☐Single or ☐Recurrent **Date & Results of PHQ9 Screening (must support diagnosis)** Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
☐Yes ☐No ☐Yes ☐No	Bipolar Disorder Schizophrenia	Type: ☐Mild ☐Moderate ☐Severe ☐Partial ☐Full Remission ☐Single or ☐Recurrent Exam Details:	☐Active/Stable ☐Resolved

SENIOR ASSESSMENT FORM

☐Yes ☐No	Drug/Alcohol	Addiction: _____ Type:_____ Frequency_____ Date Quit: ☐History Exam Details:	☐Active ☐Resolved
Endocrinology		☐ABNL Habitus ☐Goiter ☐ABNL GTT ☐Gynecomastia ☐Underweight ☐Generalized Weakness ☐Hypoglycemia ☐Polydypsia ☐Polyphagia ☐Polyuria ☐Tremors ☐Morbid Obesity ☐ Other_____	
☐Yes ☐No	Protein Calorie Mal-Nutrition	☐ Weight Loss ☐ Wasting ☐ Malnourished ☐ Supplements Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
☐Yes ☐No	★ Diabetes	Type: ☐1 ☐2 ☐Currently taking insulin **Complications:** ☐Gangrene in DM ☐Retinopathy in DM ☐ED in DM ☐Chronic Skin Ulcer in DM Fingerstick blood sugar range (low to high) for past month: Date and Result of last HgbA1c: Date and result of last Microalbuminura: Exam Details:	☐Active/Stable ☐Controlled ☐Uncontrolled
Hem/Onc			
☐Yes ☐No	Anemia	Type: _____ In Neoplastic Disease: ☐Yes ☐No Date of Last CBC: _____ Hgb_____ HCT_____ PLTS_____ Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
☐Yes ☐No	Neoplasm's	Site:_____ ☐ Chemotherapy ☐ Radiation Type:_____ Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
☐Yes ☐No	Metastatic	☐Yes ☐No Site:_____ ☐ Chemotherapy ☐ Radiation Exam Details:	☐Active/Stable ☐Progressive ☐Resolved

Patient Name: _____ DOB: ____ / ____ / _____ ☐ Male ☐ Female

SENIOR ASSESSMENT FORM

★Care for Older Adults (COA) Assessment

DOES PATIENT HAVE AN ADVANCE DIRECTIVE? ☐ YES ☐ NO
(*If No, check box to indicate that patient has been advised of their need to have an Advance Directive in place.)* ☐

Medication Reconcilliation – CPT Codes: 90862, 99605, 99606 Category II Codes: 1159F, 1160F

NAME OF MEDICATION	PRESCRIPTION	O-T-C	DOSAGE
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Current Level of Function *(Compare to initial assessment.)* **Category II Codes: 1170F**

ADL	☐ INDEPENDENT ☐ MINIMAL ASSISTANCE ☐ NEEDS ASSISTANCE ☐ TOTAL ASSIST
MOBILITY	☐ CONTROLS/MOVES ALL LIMBS AT WILL AND SAFELY INDEPENDENT ☐CONTROLS/MOVES ALL LIMBS WITH MIN. ASSISTANCE ☐ REQUIRES 2 PERSONS FOR XFER ☐ UNABLE TO POSITION CHANGE/MECHANICAL LIFT XFER
BALANCE	☐ NORMAL ☐ MIN. ASSISTANCE WITH BALANCE ☐UNSAFE BALANCE AND NEEDS MODERATE ASSISTANCE ☐ MAXIMUM ASSISTANCE NEEDED WITH 1-2 PERSONS
MENTAL STATUS	☐ ORIENTED x3 ☐ ORIENTED x2 – FOLLOWS SIMPLE COMMANDS ☐ ORIENTED x1 – INCONSISTENLY RESTLESS, AGITATED OR NERVOUS ☐ UNRESPONSIVE TO VERBAL COMMANDS
COMMUNICATIONS	☐ IMPROVED ☐ DECLINED ☐ UNCHANGED

Pain Assessment – Category II Codes: 0521F, 1125F, 1125F

Location:	**Intensity:** On a scale of 0 to 10, with 0 being no at all and 10 being the worst pain you can imagine, how much does it hurt right now? 0-------1------2-------3-------4-------5-------6-------7-------8-------9-------10 *No Pain* *Moderate Pain* *Worst Pain* *Possible*
IS PAIN CONSTANT? ☐ YES ☐ NO	TYPE OF PAIN (Example: ache, deep, sharp, hot, cold, dull, like sensitive skin)
ONSET, DURATION, VARIATIONS	WHAT RELIEVES PAIN?
OTHER COMMENTS:	

Patient Name: _____ DOB: ____ / ____ / _____ ☐ Male ☐ Female

SENIOR ASSESSMENT FORM

The following information is required for each diagnosis on the Annual Visit Form

	Diagnosis Description	Status of Diagnosis	Plan Of Care
Diagnosis #1		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-10 #1			Current RX:
Diagnosis #2		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-10 #2			Current RX:
Diagnosis #3		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-10 #3			Current RX:
Diagnosis #4		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-10 #4			Current RX:
Diagnosis #5		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-10 #5			Current RX:
Diagnosis #6		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-10 #6			Current RX:
Diagnosis #7		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-10 #7			Current RX:
Diagnosis #8		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-10 #8			Current RX:
Diagnosis #9		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-10 #9			Current RX:
Diagnosis #10		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-10 #10			Current RX:
Health Maintenance:			
Referrals:			
New RX in the last 180 days			

PCP Name: _____ Date of Service: ____ /____ /_____ Page 6 of 7

Provider Signature: _____ Provider Credentials: ☐ MD ☐ DO ☐ NP ☐ PA

SENIOR ASSESSMENT FORM

New RX in the last 180 days	