FORM DATE _____

ANNUAL WELLNESS VISIT 2023

☐ Welcome to Medicare **(G0402)** - first 12 mo of Medicare Part B Coverage ☐ Initial **(G0438)** ☐ Subsequent **(G0439)**

MEMBER _____ **MEMBER #** _____ **PCP** _____

HEALTH PLAN _____ **PREFERRED LANGUAGE** _____

GENDER _____ **AGE** _____ **DOB** _____ **DATE OF SERVICE** _____

Personal Medical History: Please indicate whether the patient has had any of the following medical problems with approximate date of illness or diagnosis:

CONDITION	YEAR	CONDITION	YEAR	CONDITION	YEAR
☐ Congestive Heart Failure		☐ Stroke		☐ Depression	
☐ High Blood Pressure		☐ Cancer		☐ Thyroid Problem	
☐ Heart Attack		☐ Diabetes		☐ High Cholesterol	
		Statin start date		☐ Asthma Control Med Start Date	

OTHER:

Family History: Please indicate if any person, related by blood, had any of the following:

CONDITION	Y	N	RELATIONSHIP	CONDITION	Y	N	RELATIONSHIP
Hypertension	☐	☐		Glaucoma	☐	☐	
Stroke	☐	☐		Cancer	☐	☐	
Heart Disease	☐	☐		Alcoholism	☐	☐	
High Cholesterol	☐	☐		Asthma/COPD	☐	☐	
Diabetes	☐	☐		Depression/Suicide	☐	☐	

Social History: Please answer all questions

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco use assessed? ☐ Yes **(1000F)** ☐ No

Does the patient smoke cigarettes? ☐ Yes **(1034F)** ☐ No

If yes, how many packs a day? _____ For how many years? _____

Counseling provided: ☐ Tobacco Abuse Counseling (Z71.6)
☐ Counseling and/or pharmacotherapy (G9906)

Alcoholic beverages? ☐ Yes **(G0442)** ☐ No

If yes, does the patient have four or more drinks in a day? ☐ Yes ☐ No

If yes, then positive for alcohol misuse; counseling done: ☐ Yes **(G0443)**

	Y	N	If yes, how often?
Recreational drugs?	☐	☐	
Counsel if at risk for STIs	☐	☐	
At risk for syphilis	☐	☐	
At risk for HIV	☐	☐	
Transportation	☐	☐	
Caregivers	☐	☐	
Recreational Activities	☐	☐	

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	Y	N		Y	N		Y	N
Alcohol Abuse/Dependence	☐	☐	Drug Abuse/Dependence?	☐	☐	Homelessness	☐	☐
Enrolled in an alcohol treatment?	☐	☐	Enrolled in Drug Treatment?	☐	☐	If yes, where does patient stay?		
If yes, Date: _____						_____		

Other Medical Care: Please list other physician or suppliers who provided medical care in the last 12 months

NAME	DATE	CONDITION

Risk of Hospital Admission? ☐ Yes ☐ No

If yes, please list the reason(s) _____

PATIENT HEALTH QUESTIONNAIRE PHQ-9 (3725F)

Over the last 2 weeks, how often has the patient been bothered by any of the following problems	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep , or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
	Addcolumns:			
	TOTAL:			

If the patient checked off any problems, how difficult have these problems, made it for the patient to do their work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Depression Severity by Total Score:

1-4 Minimal	15-19 Moderately Severe
5-9 Mild	20-27 Severe
10-14 Moderate	

NOTE: F32.X may only be used once in a person's lifetime. Use **F33.X** for recurrent episodes. (See tip sheet for more coding information)
Please document to **HIGHEST SPECIFICITY:** episode, severity, status

VITAL SIGNS

BP: _____ TEMP: _____ HT*: _____ WT*: _____ BMI:* _____ PULSE OX: _____ eGFR: _____

*Values for height, weight, and BMI are REQUIRED for validation

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PHYSICAL EXAMINATION

N Within Normal Limits **A** Abnormal

	N	A	FINDINGS
General Appearance	☐	☐	
HEENT	☐	☐	
Cardiovascular	☐	☐	
Respiratory	☐	☐	
Gastrointestinal	☐	☐	
Hematologic/lymphatic/immuno	☐	☐	
Musculoskeletal	☐	☐	
Skin	☐	☐	
Genitourinary Neurological	☐	☐	
Other	☐	☐	

COGNITIVE ASSESSMENT

Ask patient to remember the following three words, and ask the patient to repeat the words to ensure the learning was correct

BANANA **SUNRISE** **CHAIR**

Ask patient to draw hands to read 20 minutes after 8 (or 10 minutes after 11)

Use another sheet if necessary

Ask the patient to repeat the three words given previously

_____ _____ _____

CARE FOR OLDER ADULTS

FUNCTIONAL STATUS ASSESSMENT (1170F) *CHECK AT LEAST ONE*

☐ Assessment of instrumental activities of daily livings (ADLs) such as meal preparation, shopping for groceries, using public transportation, housework, home repair, laundry, taking medications or handling finances. Results using a standardized functional status assessment tool.

☐ Assessment of three of the following four components: cognitive status; ambulation status; sensory ability; other functional independence such as exercise, ability to perform job. Results using a standardized functional status assessment tool.

☐ Assessment of ADLs such as bathing, dressing, eating, transferring, walking, using toilet.

OTHER ASSESSMENTS

☐ Physical activity assessment **(1003F)**

Fall risk assessment:

☐ No Falls

☐ Fallen twice or more **(1100F)**

☐ Urinary incontinence assessed **(1090F)**

☐ Advance directive—Living will:

☐ Yes ☐ No

☐ Discussed **(1158F)**

☐ Advance directive in chart **(1157F)**

Risk for Admission to SNF? ☐ Yes ☐ No. If yes, list reason(s): _____

Medications: Please list current prescription and non-prescription medicines, vitamins, home remedies, herbs.

CURRENT / ACTIVE MEDICATION

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medication List Documented? ☐ Yes **(1159F)*** ☐ No

Medication Reviewed & Reconciled ☐ Yes **(1160F)*** ☐ No

*Both codes are required to fulfill quality measure requirement

Allergies or Reaction to Medication:

_____

_____

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PAIN SCREENING

0 | 1 2 3 4 5 6 7 8 9 10

No pain (1126F) | Pain is present (1125F)

REVIEW OF SYSTEMS

Y N ALLERGY
- ☐ ☐ Anaphylaxis
- ☐ ☐ Food Intolerance
- ☐ ☐ Itching
- ☐ ☐ Nasal Congestion
- ☐ ☐ Rash

Y N BLOOD
- ☐ ☐ Bleeding/bruising tendency

Y N CONSTITUTIONAL
- ☐ ☐ Chills
- ☐ ☐ Daytime drowsiness
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Night sweats

Y N EAR/NOSE/THROAT
- ☐ ☐ Hearing difficulty/loss
- ☐ ☐ Ringing in ears (tinnitus)
- ☐ ☐ Frequent each aches
- ☐ ☐ Ear discharge
- ☐ ☐ Attacks of vertigo
- ☐ ☐ Sinus trouble
- ☐ ☐ Nasal blockage
- ☐ ☐ Frequent sneezing
- ☐ ☐ Frequent sore throat
- ☐ ☐ Snoring
- ☐ ☐ Recent change in voice
- ☐ ☐ Sleep apnea
- ☐ ☐ Difficulty in swallowing
- ☐ ☐ Nose bleeds

Y N ENDOCRINE/METABOLISM
- ☐ ☐ Unusual hair loss/growth

Y N EYES
- ☐ ☐ Wears glasses/contacts
- ☐ ☐ Cataracts
- ☐ ☐ Problems with vision

Y N HEART/CIRCULATION
- ☐ ☐ Chest discomfort (angina)
- ☐ ☐ Shortness of breath w/activity
- ☐ ☐ Blood clot in artery/vein
- ☐ ☐ Aneurysm of blood vessel
- ☐ ☐ Palpitations, racing/pounding heart
- ☐ ☐ Swelling of legs
- ☐ ☐ Heart surgery
- ☐ ☐ Black out spells
- ☐ ☐ Heart murmur

Y N KIDNEYS/URINARY TRACT
- ☐ ☐ Bladder infections in past year
- ☐ ☐ Pain/burning w/urination
- ☐ ☐ Trouble starting urinary stream
- ☐ ☐ Frequent night urination
- ☐ ☐ Kidney stones/infection
- ☐ ☐ Blood in urine in past year

Y N MEN
- ☐ ☐ Testicular Swelling
- ☐ ☐ Prostate problems
- ☐ ☐ Frequent urination

Y N MUSCLES/BONES/JOINTS
- ☐ ☐ Arthritis/other joint disease
- ☐ ☐ Chronic back trouble

Y N NERVOUS SYSTEM
- ☐ ☐ Headache/migraine

Y N PSYCHOLOGICAL
- ☐ ☐ Loss/change in appetite
- ☐ ☐ Behavioral change
- ☐ ☐ Confusion
- ☐ ☐ Insomnia
- ☐ ☐ Memory loss
- ☐ ☐ Mood change

Y N RESPIRATORY
- ☐ ☐ Cough
- ☐ ☐ Shortness of breath
- ☐ ☐ Coughing up blood

Y N SKIN
- ☐ ☐ Rash/psoriasis/dermatitis
- ☐ ☐ New skin growth or mole

Y N STOMACH/INTESTINES
- ☐ ☐ Ulcer
- ☐ ☐ Hiatal hernia
- ☐ ☐ Frequent heartburn/indigestion
- ☐ ☐ Blood from bowels/rectum
- ☐ ☐ Gall bladder attacks/gallstones
- ☐ ☐ Poor appetite
- ☐ ☐ Frequent diarrhea
- ☐ ☐ Abnormal stool
- ☐ ☐ Acid reflux

Y N WOMEN
- ☐ ☐ Painful periods
- ☐ ☐ Excessive flow
- ☐ ☐ Hot flash/menopause symptoms
- ☐ ☐ Vaginal burning
- ☐ ☐ Irregular cycles
- ☐ ☐ Currently pregnant

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PREVENTIVE SCREENING CHECKLIST		COMPLETED	RESULT	DATE DONE	PROVIDER/FACILITY
Flu vaccine in current season (4274F)		Y ☐ N ☐			
Pneumococcal vaccine age 60+ (4040F) Totaldoses: _____		Y ☐ N ☐			
☐ Tetanus vaccine		Y ☐ N ☐			
☐ Zoster vaccine - Totaldoses: _____		Y ☐ N ☐			
Patients between 51 and 75 years of age: (**3017F** PLEASE SUBMIT REPORT) PLEASE SUBMIT REPORT	☐ Colonoscopy in last 10 years	Y ☐ N ☐			
	☐ Flex Sig in last 5 years	Y ☐ N ☐			
	☐ CT Colonography in last 5 years	Y ☐ N ☐			
	☐ FOBT in current year	Y ☐ N ☐			

MALE ONLY	COMPLETED	RESULT	DATE DONE	PROVIDER/FACILITY
☐ Lipid disorder screening	Y ☐ N ☐			
☐ Abdominal aortic aneurysm screening if ever smoked	Y ☐ N ☐			
☐ Prostate-specific antigen (PSA) screening	Y ☐ N ☐			

FEMALE ONLY	COMPLETED	RESULT	DATE DONE	PROVIDER/FACILITY
Women 50-74 years: Mammogram in current or prior year documented and reviewed (3014F) PLEASE SUBMIT REPORT	Y ☐ N ☐			
Pap Smear (age 21-64) with HPV co-testing (age 30-64) (3015F)	Y ☐ N ☐			
65 years or older: Bone density test every 2 years if normal	Y ☐ N ☐			
Women with bone fracture in last 12 months: Bone density test or on medication to treat or prevent osteoporosis (3095F)	Y ☐ N ☐	T-SCORE		
Lipid disorder screening if at risk for coronary heart disease	Y ☐ N ☐			

MEMBER WITH CARDIOVASCULAR DISEASE	COMPLETED	RESULT	DATE DONE	PROVIDER/FACILITY
Patients w/ cardiovascular conditions in current or prior year: Lab test for LDL-C in current year Most current LDL-C value in current year is <100mg/dL	Y ☐ N ☐ Y ☐ N ☐			
Hospitalized and discharged with diagnosis of AMI: On beta blocker treatment for at least 6 months from discharge (4008F)	Y ☐ N ☐			
Age 45-79: Use of aspirin to reduce risk of myocardial infarction (heart attack) (4086F)	Y ☐ N ☐			

MEMBER WITH DIABETES	COMPLETED	RESULT	DATE DONE	PROVIDER/FACILITY
Most recent HbA1C in current year ≥ 7.0 and < 8.0 (**3051F**); ≥ 8.0 and ≤ 9.0 (**3052F**); > 9.0 (**3046F**)	Y ☐ N ☐			
Dilated ret inal eye exam by eye care professional with evidence of diabetic retinopathy (2022F) or without evidence of diabetic retinopathy (2023F), OR Negative result in the prior year (3072F) **PLEASE SUBMIT REPORT**	Y ☐ N ☐	RETINOPATHY Y ☐ N ☐		
Kidney Health Evaluation for Patients with Diabetes (KED) during current year. Required - eGFR (**80047**); AND one of the following: uACR (**9318-7**) OR urine creatinine (**82570**) & urine albumin (**82043**)	Y ☐ N ☐			

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MEMBER WITH DIABETES CONTINUED	DATE DONE	RESULT (PLEASE CIRCLE)
Foot Exam with monofilament test **(2028F)**		Normal LL skin ulcer Neuropathy Absence of foot pulse

MEMBER WITH RHEUMATOID ARTHRITIS	ON TREATMENT		
	CURRENT MEDICATION	DATE DONE	PROVIDER/FACILITY
Patients with diagnosis of RA should be on DMARD **(4187F)**			

MEMBER WITH COPD	COMPLETED		
	RESULT	DATE DONE	PROVIDER/FACILITY
Spirometry test to confirm diagnosis within 1 year of diagnosis **(3023F)**			

MEMBER ON CERTAIN MEDICATION	COMPLETED	RESULT	DATE DONE	PROVIDER/FACILITY
Monitoring of potassium, creatinine and—if applicable—digoxin level for patients currently taking for more than six months: ACE inhibitor or ARB **(4188F)** ☐ Diuretic **(4190F)** or Digoxin **(4189F)**	Y ☐ N ☐			

Is patient on Anticonvulsants for 6 months or more? **Y** ☐ **N** ☐ If Yes, has blood test been completed to test blood for medication levels? **(4191F)** **Y** ☐ **N** ☐

STATUS CONDITIONS	DIAGNOSIS DATE
☐ History of Hysterectomy with no residual cervix/TAH **(Z90.710)**	Date: _____
☐ Pregnancy **(various codes)** - specify	Date: _____
☐ HIV **(Z21)**	Date: _____
☐ AIDS **(B20)** - specify	Date: _____
☐ Chronic Renal Failure **(N18)** - specify stage	Date: _____
☐ ESRD **(N18.6)**	Date: _____
☐ Dialysis **(Z99.2)**	Date: _____
☐ Kidney Transplant **(Z94.0)**	Date: _____
☐ Dialysis **(Z99.2)**	Date: _____
☐ Colorectal Cancer **(Z85.03-Z85.04)**	Date: _____
☐ Total Colectomy **(Z90.49)**	Date: _____
☐ Other Personal History of Cancer **(Z85)** - specify	Date: _____
☐ Artificial opening status **(Z93)**	Date: _____
☐ Amputation **(Z89)** - specify	Date: _____
☐ Morbid obesity **(E66)** –specify criteria	Date: _____
☐ Malnutrition **(E43-E44)** –specify criteria	Date: _____
☐ Cerebral Palsy **(G80)** or Other Paralysis **(G81-G82)** - specify Sequelae	Date: _____
☐ of Stroke **(I69)** - specify	Date: _____
☐ Parkinson's **(G20)** or Parkinsonism **(G21)** - specify:	Date: _____

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Please document all chronic conditions with status and plan OR submit progress note with all chronic conditions with status and plan.

DIAGNOSTIC DESCRIPTION	STATUS	PLAN
Encounter for general examination	☐ With normal findings ☐ With abnormal findings	
1	☐ New ☐ Resolved ☐ Stable ☐ Improved ☐ Worsened	
2	☐ New ☐ ☐ Stable ☐ ☐ Worsened	
3	☐ New ☐ Resolved ☐ Stable ☐ Improved ☐ Worsened	
4	☐ New ☐ ☐ Stable ☐ ☐ Worsened	
5	☐ New ☐ Resolved ☐ Stable ☐ Improved ☐ Worsened	
6	☐ New ☐ ☐ Stable ☐ ☐ Worsened	
7	☐ New ☐ Resolved ☐ Stable ☐ Improved ☐ Worsened	
8	☐ New ☐ ☐ Stable ☐ ☐ Worsened	
9	☐ New ☐ Resolved ☐ Stable ☐ Improved ☐ Worsened	

Useanothersheetifnecessary **Attach EHR note if documenting in EHR**

CLAIM MUST BE SUBMITTED WITH ALL RELATED ICD-10, CPT, AND CPT II CODES
Use CPT 99499 to submit more than 12 ICD-10 codes

Printed Name and Credential: _____

Signature: _____ Date Signed: _____