



DATE OF SERVICE _____

ANNUAL WELLNESS VISIT 2025

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
<input type="checkbox"/> Congestive Heart Failure	_____	<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Thyroid Problem	_____
<input type="checkbox"/> Heart Attack	_____	<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> High Cholesterol	_____
		Statin start date	_____	<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma/COPD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Depression/Suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

Alcohol Abuse/Dependence **Y N**

 Enrolled in an alcohol treatment?

Drug Abuse/Dependence? **Y N**

 Enrolled in Drug Treatment?

Homelessness **Y N**

 If yes, where does patient stay? _____

If yes, Date: _____

Social Determinates of Health G0136 Food Insecurity

Have you worried about running out of food in the last 12 months?

- No
 Yes
 Sometimes

Do you always have enough food for you and your family?

- No
 Yes
 Sometimes

Transportation Needs

Do you lack transportation to medical appointments?

- No
 Yes
 Sometimes

Do you lack transportation to non-medical appointments and errands?

- No
 Yes
 Sometimes

Housing Stability

Have you been unable to pay for housing in the last 12 months?

- No
 Yes
 Sometimes

Are you worried about losing your housing?

- No
 Yes
 Sometimes

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

NAME

DATE

CONDITION

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

Add columns: _____

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

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:



0

No pain(1126F)

1

2

3

4

5

6

7

8

9

10

Pain is present (1125F)

PAIN SCREENING**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 ear 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

MEMBER

DATE OF SERVICE

PREVENTIVE SCREENING CHECKLIST		COMPLETED	RESULT	DATE DONE	PROVIDER/FACILITY
Flu vaccine in current season (4274F)		Y <input type="checkbox"/> N <input type="checkbox"/>			
Pneumococcal vaccine age 60+ (4040F) Totaldoses: _____		Y <input type="checkbox"/> N <input type="checkbox"/>			
<input type="checkbox"/> Tetanus vaccine		Y <input type="checkbox"/> N <input type="checkbox"/>			
<input type="checkbox"/> Zoster vaccine - Totaldoses: _____		Y <input type="checkbox"/> N <input type="checkbox"/>			
Patients between 51 and 75 years of age: (3017F PLEASE SUBMIT REPORT) PLEASE SUBMIT REPORT	<input type="checkbox"/> Colonoscopy in last 10 years	Y <input type="checkbox"/> N <input type="checkbox"/>			
	<input type="checkbox"/> Flex Sig in last 5 years	Y <input type="checkbox"/> N <input type="checkbox"/>			
	<input type="checkbox"/> CT Colonography in last 5 years	Y <input type="checkbox"/> N <input type="checkbox"/>			
	<input type="checkbox"/> FOBT in current year	Y <input type="checkbox"/> N <input type="checkbox"/>			
MALE ONLY		COMPLETED	RESULT	DATE DONE	PROVIDER/FACILITY
<input type="checkbox"/> Lipid disorder screening		Y <input type="checkbox"/> N <input type="checkbox"/>			
<input type="checkbox"/> Abdominal aortic aneurysm screening if ever smoked		Y <input type="checkbox"/> N <input type="checkbox"/>			
<input type="checkbox"/> Prostate-specific antigen (PSA) screening		Y <input type="checkbox"/> N <input type="checkbox"/>			
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 <input type="checkbox"/> N <input type="checkbox"/>			
Pap Smear (age 21-64) with HPV co-testing (age 30-64) (3015F)		Y <input type="checkbox"/> N <input type="checkbox"/>			
65 years or older: Bone density test every 2 years if normal		Y <input type="checkbox"/> N <input type="checkbox"/>			
Women with bone fracture in last 12 months: Bone density test or on medication to treat or prevent osteoporosis (3095F)		Y <input type="checkbox"/> N <input type="checkbox"/>	T-SCORE		
Lipid disorder screening if at risk for coronary heart disease		Y <input type="checkbox"/> N <input type="checkbox"/>			
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 <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>			
Hospitalized and discharged with diagnosis of AMI: On beta blocker treatment for at least 6 months from discharge (4008F)		Y <input type="checkbox"/> N <input type="checkbox"/>			
Age 45-79: Use of aspirin to reduce risk of myocardial infarction (heart attack) (4086F)		Y <input type="checkbox"/> N <input type="checkbox"/>			
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 <input type="checkbox"/> N <input type="checkbox"/>			
Dilated retinal 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 <input type="checkbox"/> N <input type="checkbox"/>	RETINOPATHY Y <input type="checkbox"/> N <input type="checkbox"/>		
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 <input type="checkbox"/> N <input type="checkbox"/>			

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) <input type="checkbox"/> Diuretic (4190F) or Digoxin (4189F)	Y <input type="checkbox"/> N <input type="checkbox"/>		

Is patient on Anticonvulsants for 6 months or more? Y N

If Yes, has blood test been completed to test blood for medication levels? Y N (4191F)

STATUS CONDITIONS

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

DIAGNOSIS DATE

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

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	<input type="checkbox"/> With normal findings <input type="checkbox"/> With abnormal findings	
1	<input type="checkbox"/> New <input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Improved <input type="checkbox"/> Worsened	
2	<input type="checkbox"/> New <input type="checkbox"/> <input type="checkbox"/> Stable <input type="checkbox"/> <input type="checkbox"/> Worsened	
3	<input type="checkbox"/> New <input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Improved <input type="checkbox"/> Worsened	
4	<input type="checkbox"/> New <input type="checkbox"/> <input type="checkbox"/> Stable <input type="checkbox"/> <input type="checkbox"/> Worsened	
5	<input type="checkbox"/> New <input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Improved <input type="checkbox"/> Worsened	
6	<input type="checkbox"/> New <input type="checkbox"/> <input type="checkbox"/> Stable <input type="checkbox"/> <input type="checkbox"/> Worsened	
7	<input type="checkbox"/> New <input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Improved <input type="checkbox"/> Worsened	
8	<input type="checkbox"/> New <input type="checkbox"/> <input type="checkbox"/> Stable <input type="checkbox"/> <input type="checkbox"/> Worsened	
9	<input type="checkbox"/> New <input type="checkbox"/> Resolved <input type="checkbox"/> Stable <input type="checkbox"/> Improved <input type="checkbox"/> Worsened	

Use another sheet if necessary

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: _____