MEDICARE PREVENTIVE PHYSICAL EXAM

Family Practice Management®

Today's Date _____

☐ Initial Preventive Physical Exam ("Welcome to Medicare" Physical)	☐ Initial annual wellness visit	☐ Subsequent annual wellness visit	☐ Other

Patient name	Medical record #	Date of birth
Staff conducting initial intake	Date of last exam	Medicare B eligibility date

Language or other communication barriers: (describe)	Sex	LMP
Interpreter or other accommodation provided today: (describe)	Gravida/para	Year of menopause

Vital signs	Ht	Wt	BMI	Waist	BP	Temp	P/R

☐ Patient completed health risk assessment (Annual Wellness Visit requirement only; e.g. www.medicalhealthassess.org)

SOCIAL HISTORY						
Tobacco	☐ Current	Type:	Freq:	☐ 2nd hand	☐ Never	☐ Prior use Quit date:
ETOH	☐ Never	☐ Occasional	☐ Daily	History of ETOH: (describe)		
Diet notes				**Caffeine**	☐ Never	☐ Occasional ☐ Daily
Drug abuse	☐ Never	☐ Occasional	☐ Daily	☐ Prior use	Quit date:	
	History of drug abuse: (describe)					
Occupation				**Exercise type/frequency**		
Home environment	☐ Private home	☐ Assisted living	☐ Other: (describe)			

FAMILY HISTORY use ✔ to indicate positive history									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart disease									
Stroke									
Kidney disease									
Obesity									
Genetic disorder									
Liver disease									

Patient's name: _____ Today's date: _____

FAMILY HISTORY continued use ✔ to indicate positive history									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Depression or manic depressive disorder									
Colon or rectal cancer									
Breast cancer									
Other cancer									
Other: _____									

MEDICAL HISTORY				
Hospital visits since last office visit/reason	**Facility**	**Attending physician**	**Date of hospital visit**	**Past surgeries (include date and description of any complications)**

INJURIES (SINCE LAST PHYSICAL EXAM)		
Date	**Type**	**Treatment received**

ALLERGY LIST	
Allergies	**Type of reaction**

MEDICATION LIST if noted elsewhere in chart, indicate location: _____					
Herbals, supplements, OTC drugs, substances of abuse	**Date started**	**Date discontinued**	**Rx meds, dose, frequency, route**	**Date started**	**Date discontinued**

Patient's name: _____ Today's date: _____

MEDICATION LIST continued if noted elsewhere in chart, indicate location: _____					
Herbals, supplements, OTC drugs, substances of abuse	**Date started**	**Date discontinued**	**Rx meds, dose, frequency, route**	**Date started**	**Date discontinued**

PROBLEM LIST				
Chronic problems	**Date added**	**Managing physician (if other)**	**Date updated**	**Initial**
Acute problems (R=resolved)	**Date added**	**Managing physician (if other)**	**Date updated**	**Initial**

OTHER PHYSICIANS AND PROVIDERS OF CARE this documentation not required for IPPE		
Name & specialty/provider type	**Type of care**	**Date discontinued**

☐ **Physician/other provider sign here to indicate review/notation of pertinent history:** _____

Patient's name: _____ Today's date: _____

DEPRESSION SCREENING		
1. Over the past two weeks, has the patient felt down, depressed or hopeless?	☐ Yes	☐ No
2. Over the past two weeks, has the patient felt little interest or pleasure in doing things?	☐ Yes	☐ No

FUNCTIONAL ABILITY/SAFETY SCREENING		
1. Was the patient's timed Up & Go test unsteady or longer than 30 seconds?	☐ Yes	☐ No
2. Does the patient need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money?	☐ Yes	☐ No
3. Does the patient's home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting?	☐ Yes	☐ No
4. Have you noticed any hearing difficulties?	☐ Yes	☐ No
Hearing evaluation:		
A "yes" response to any of the above questions regarding depression or function/safety should trigger further evaluation.		

EVALUATION OF COGNITIVE FUNCTION this documentation not required for IPPE
Mood/affect
Appearance
Family member/caregiver input

VISION EXAMINATION
Visual acuity: L _____ **R** _____

ELECTROCARDIOGRAM REFERRAL OR RESULT if performed/ordered (covered benefit for IPPE)

ADVICE/REFERRALS based on history, exam and screening (including risks, interventions underway or planned, and benefits)

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CHRONIC CARE MANAGEMENT
Patient eligible? ☐ Yes ☐ No If eligible, patient agreement form completed and documented? ☐ Yes ☐ No If agreement, care coordinator notified? ☐ Yes ☐ No

POTENTIAL RECOMMENDATIONS NOT COVERED AS MEDICARE PART B PREVENTIVE SERVICES **this documentation not required for IPPE** *Patients should contact their Part-D plan for information on preventive vaccines benefits.*	
Varicella vaccine	Aspirin therapy
Zoster vaccine (once)	Calcium supplement
Tdap vaccine (10 years)	Social services
Td vaccine (10 years)	Dietary counseling
MMR vaccine	
Meningococcal vaccine	
Hep A vaccine	

HANDOUTS REVIEWED AND DISCUSSED WITH PATIENT

DISCUSSION OF ADVANCE DIRECTIVE (PATIENT PREFERENCE, PHYSICIAN AGREEMENT/DISAGREEMENT):

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Create two copies of this page: One for your charts and one to give to your patient.

COUNSELING AND REFERRAL OF OTHER PREVENTIVE SERVICES	
Preventive Service	**Recommendation/Scheduled/Next Due**
Abdominal aortic aneurysm screening (covered only if ordered at time of IPPE)	
Alcohol misuse screening and counseling	
Annual Wellness Visit (AWV) - includes health risk assessment and a personalized prevention plan of service (PPPS); first visit 11 full months after IPPE and subsequent visit 11 full months after first or most recent AWV	
Bone mass measurements	
Breast cancer screening - mammogram	
Cardiovascular disease screening laboratory tests - Lipid panel	
Cardiovascular disease - intensive behavioral therapy	
Cervical and vaginal cancer screening - Pelvic and breast exam including Pap smear	
Colorectal Cancer Screening - Fecal occult blood test; flexible sigmoidoscopy; colonoscopy; stool-based DNA and fecal occult hemoglobin	
Colorectal cancer screening - Barium enema - patient cost co-pay applies, deductible waived	
Depression screening	
Diabetes screening - glucose testing	
Diabetes self-management training - patient cost 20% after deductible (program accredited by the American Diabetes Association, American Association of Diabetes Educators or the Indian Health Service)	
Glaucoma test -patient cost 20% after deductible	
Hepatitis B vaccine	
Hepatitis C screening test	
HIV screening	
Influenza vaccination	
Lung cancer screening - Low dose computed tomography (LD-CT) - This benefit may not yet be available in all locales as facilities must meet specific requirements to provide the service.	
Medical nutrition therapy for diabetes or kidney disease (provided by nutritionist or dietitian)	
Obesity screening and intensive behavioral therapy	
Pneumococcal vaccination	
Prostate cancer screening - prostate specific antigen (PSA)	
Sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and/or Hepatitis B	
Sexually transmitted infection high intensity behavioral counseling	

Physician's signature: _____ **Date:** _____