A Northside Network Provider

Patient's name: _____ **Date of Birth:** _____

Medicare B enrollment date: _____ *

Today's date: _____

Health Risk Assessment has been reviewed by physicians, signed and dated: Initial _____

MEDICAL/SOCIAL HISTORY

Past personal illnesses or injuries:

Injury/Illness/Surgery	Date	Hospitalized? (Indicate Yes or No)

Medications, supplements and vitamins:

Drug allergies/other allergies:

Social history notes (including diet, physical activities, alcohol use, drug use and tobacco use):

Family history notes:

	Mother	Father	Brother	Sister	Son	Daughter
Deceased						
Hypertension						
Stroke						
Diabetes						
Kidney disease						
Heart disease						
Cancer						
Other						

Other physicians and providers/suppliers of care (include provide name, specialty & type of care)

WELCOME TO MEDICARE
IPPE/ANNUAL WELLNESS VISIT

DEPRESSION SCREEN**

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

TO BE COMPLETED WITH THE PROVIDER

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____ BMI:_____

Visual Acuity **(IPPE only)**:

	With Correction	Without correction
L		
R		
Both		

FUNCTIONAL ABILITY/SAFETY SCREEN**

1. Was the patient's timed Up & Go test unsteady or long than 30 seconds? ☐ Yes ☐ No
2. Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? ☐ Yes ☐ No
3. Does your 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

****If further evaluation is needed, please use additional PHQ-9 depression screening and/or fall prevention checklist forms.**

EVALUATION OF COGNITIVE FUNCTION

Mood/Affect: _____

Appearance: _____

Family member/Caregiver input: _____

ELECTROCARDIOGRAM (G0403-EKG) – Only at the time of the IPPE

Referral or result: _____

EVALUATIONS/REFERRALS BASED ON HISTORY, EXAM AND SCREENING:

DISCUSSION OF ADVANCE DIRECTIVE (PATIENT PREFERENCE, PHYSICIAN AGREEMENT/DISAGREEMENT-if patient consents):

☐ **Reviewed medical and family history for opioid use and if applicable, patient was assessed for non-opioid pain therapy replacement.**

Physicians signature: _____ **Date:** _____

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