755 Mt. Vernon Hwy, NE
Suite 400
Sandy Springs, GA 30328
Phone: 404-252-4100
Fax: 404-252-6740

NORTHSIDE HOSPITAL

Mount Vernon Internal Medicine

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

WELCOME TO MEDICARE
IPPE/ANNUAL WELLNESS VISIT

DEPRESSION SCREEN*

1. Over the past 2 weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ No
2. Over the past 2 weeks, have you felt little interest/pleasure in doing things? ☐ Yes ☐ No

TO BE COMPLETED WITH THE PROVIDER

PHYSICAL EXAMINATION

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

Visual Acuity:

	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

*A "yes" answer to any of the questions regarding depression or function/safety should trigger further evaluation, screenings or referrals.

(Use additional screening questionnaires)

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):

☐ **List of Community Resources was given to patient**

Physicians signature: _____ **Date:** _____

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(must be viewed by physician, signed and dated)

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

Medicare B eligibility date: _____ **Today's date:** _____

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

1. What is your age? ☐ 65-69 ☐ 70-79 ☐ 80 or older
2. Are you a female or male? ☐ Male ☐ Female
3. During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

   ☐ Not at all
   ☐ Slightly
   ☐ Moderately
   ☐ Quite a bit
   ☐ Extremely

4. During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

   ☐ Not at all
   ☐ Slightly
   ☐ Moderately
   ☐ Quite a bit
   ☐ Extremely

5. During the past four weeks, how much bodily pain have you generally had?

   ☐ No pain
   ☐ Very mild pain
   ☐ Mild pain
   ☐ Moderate pain
   ☐ Severe pain

6. During the past four weeks, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

   ☐ Yes, as much as I wanted
   ☐ Yes, quite a bit
   ☐ Yes, some
   ☐ Yes, a little
   ☐ No, not at all

7. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?

   ☐ Very heavy
   ☐ Heavy
   ☐ Moderate
   ☐ Light
   ☐ Very light

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?) ☐ Yes ☐ No

HEALTH RISK ASSESSMENT

9. Can you go shopping for groceries or clothes without someone's help? ☐ Yes ☐ No

10. Can you prepare your own meals? ☐ Yes ☐ No

11. Can you do your housework without help? ☐ Yes ☐ No

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around in the house? ☐ Yes ☐ No

13. Can you handle your own money without help? ☐ Yes ☐ No

14. During the past four weeks, how would you rate your health in general?

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

15. How have things been going for you during the past four weeks?

☐ Very well, could hardly be better
☐ Pretty well
☐ Good and bad parts, about equal
☐ Pretty bad
☐ Very bad; could hardly be worse

16. Are you having difficulties driving your car?

☐ Yes, often
☐ Sometimes
☐ No
☐ Not applicable, I do not use a car

17. Do you always fasten your seat belt when you are in a car?

☐ Yes, usually
☐ Yes, sometimes
☐ No

18. How often during the past four weeks have you been *bothered* by any of the following problems?

Please indicate with: Never, Seldom, Sometimes, Often or Always

Falling or *dizzy* when standing up_____
Sexual problems _____
Trouble eating well _____
Teeth or denture problems_____
Problems using the telephone _____
Tiredness or fatigue_____

19. Have you fallen two or more times in the past year? ☐ Yes ☐ No

20. Are you afraid of falling? ☐ Yes ☐ No

21. Are you a smoker?

☐ No
☐ Yes, and I might quit
☐ Yes, but I'm not ready to quit

22. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?

☐ 10 or more drinks per week
☐ 6-9 drinks per week
☐ 2-5 drinks per week
☐ One drink or less per week
☐ No alcohol at all

23. Do you exercise for about 20 minutes three or more days a week?

☐ Yes, most of the time
☐ Yes, some of the time
☐ No, I usually do not exercise this much

24 Have you been given any information to help you with the following:

Hazards in your house that might hurt you? ☐ Yes ☐ No
Keeping track of your medications? ☐ Yes ☐ No

25. How often do you have trouble taking medicines the way you have been told to take them?

☐ I do not have to take medicine
☐ Sometimes I take them as prescribed
☐ I always take them as prescribed
☐ I seldom take them as prescribed

26. How confident are you that you can control and manage most of your health problems?

☐ Very confident
☐ Not very confident
☐ Somewhat confident
☐ I do not have any health problems

27. What is your race? (Check all that apply)

☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaska Native
☐ Hispanic or Latino origin or descent
☐ Other _____

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Provider signature: _____ Date: _____