# Patient Questionnaire

The following information is being collected today as part of an Annual Wellness Visit. We understand that some of this information may have already been communicated to the doctor, but we would like to ensure that we keep your medical records up to date. If you have any questions, please let us know.

| Patient Name | Date of Birth | Physician Name | Today's Date |
|---|---|---|---|
| | | | |

## MEDICAL HISTORY

## SURGICAL HISTORY

## MEDICATIONS

List all medications including OTCs, vitamins/minerals, and dietary supplements including dosage, frequency, and route of administration

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## GENERAL HEALTH & HEALTH MANAGEMENT

| | |
|---|---|
| In general, would you say your health is | ☐ Excellent ☐ Very Good ☐ Good ☐ Fair/Poor |
| Please describe the current condition of your mouth and teeth (including false teeth or dentures)? | ☐ Excellent ☐ Very Good ☐ Good ☐ Fair/Poor |
| In the past 7 days, how much pain have you felt? | ☐ None ☐ Some ☐ A lot |
| How confident are you that you can control and manage most of your health problems? | ☐ I do not have any health problems ☐ Confident ☐ Somewhat confident ☐ Not Very Confident |
| How often do you have trouble taking medicines the way that you have been told to take them? | ☐ Do not take Medications ☐ Always as prescribed ☐ Sometimes as prescribed ☐ Seldom as prescribed |

## FAMILY HISTORY

| | Father | Mother | Children | Sibling | Grandparents |
|---|---|---|---|---|---|
| Hypertension | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dementia | ☐ | ☐ | ☐ | ☐ | ☐ |

## VACCINATION & IMMUNIZATIONS

| | |
|---|---|
| Did you receive a Flu Immunization between October 1, 2015 through March 31, 2016? | ☐ Yes ☐ No |
| When would you say you received your last Flu shot? | _____ / ____ /_____ Month / Day / Year |
| Have you ever had a Pneumonia Vaccination? | ☐ Yes ☐ No |

## DIAGNOSTIC HISTORY

Please complete the following section with as much information as possible. Leave a section blank, if the section does not apply to you or if you do not remember the information.

| | | | |
|---|---|---|---|
| Colonoscopy | _____ / ____ /_____ Month / Day / Year | _____ Physician | ☐ No Polyps ☐ Positive for Polyps ☐ Don't Know ☐ Other Results |
| Eye Exam | _____ / ____ /_____ Month / Day / Year | _____ Physician | ☐ Normal ☐ Abnormal Results |
| Diabetic Eye Exam | _____ / ____ /_____ Month / Day / Year | _____ Physician | ☐ Normal ☐ Abnormal Results |
| Echocardiogram | _____ / ____ /_____ Month / Day / Year | _____ Physician | ☐ Normal ☐ Abnormal Results |

### FEMALES ONLY

| | | | |
|---|---|---|---|
| Last Mammogram | _____ / ____ /_____ Month / Day / Year | _____ Physician | ☐ Normal ☐ Abnormal Results |

## DEPRESSION SCREENING

| In the Past 2 weeks: | Not at All | 1 – 3 Days | Half the Days | Everyday |
|---|---|---|---|---|
| I have little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| I'm feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| I'm having trouble falling asleep, staying asleep or sleeping too much | 0 | 1 | 2 | 3 |
| I'm feeling tired or have little energy | 0 | 1 | 2 | 3 |
| I haven't had an appetite or am overeating | 0 | 1 | 2 | 3 |
| I'm feeling bad about myself, I feel I've let my family or myself down | 0 | 1 | 2 | 3 |
| I have trouble concentrating on things such as reading the paper or watching TV | 0 | 1 | 2 | 3 |
| People have noticed that my speech slowed down or is rushed like I am restless | 0 | 1 | 2 | 3 |
| I have thoughts I would be better off dead or have thought about hurting myself in someway | 0 | 1 | 2 | 3 |
| (OFFICE USE ONLY ) **TOTALS** | | | | |
| If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | ☐ Not at All | ☐ Somewhat Difficult | ☐ Very Difficult | ☐ Extremely Difficult |

## ACTIVITIES OF DAILY LIVING

| | |
|---|---|
| During the past 4 weeks, was someone available to help you if you needed and wanted help? | ☐ No, Not at all ☐ Yes, Sometimes ☐ Yes, Always |

In the past 4 weeks, have you had any trouble doing any of the following? If applicable, please list an individual who helped complete the task.

| | |
|---|---|
| Take medications | ☐ No difficulty ☐ Yes, Sometimes ☐ Yes, Require Assistance from _____ |
| Getting around the home | ☐ No difficulty ☐ Yes, Sometimes ☐ Yes, Require Assistance from _____ |
| Bathing and Dressing | ☐ No difficulty ☐ Yes, Sometimes ☐ Yes, Require Assistance from _____ |
| Using the Telephone | ☐ No difficulty ☐ Yes, Sometimes ☐ Yes, Require Assistance from _____ |
| Traveling | ☐ No difficulty ☐ Yes, Sometimes ☐ Yes, Require Assistance from _____ |
| Grocery Shopping | ☐ No difficulty ☐ Yes, Sometimes ☐ Yes, Require Assistance from _____ |
| Preparing Meals | ☐ No difficulty ☐ Yes, Sometimes ☐ Yes, Require Assistance from _____ |
| Housework | ☐ No difficulty ☐ Yes, Sometimes ☐ Yes, Require Assistance from _____ |
| Managing Money | ☐ No difficulty ☐ Yes, Sometimes ☐ Yes, Require Assistance from _____ |
| Do you have a living will? | ☐ Yes ☐ No |

## TOBACCO AND ALCOHOL USE ASSESSMENT

| | |
|---|---|
| Have you used any form of tobacco products in the past 6 months? | ☐ Yes ☐ No |
| How many years have you used tobacco products? | _____ |
| What form of tobacco do you use? | ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe ☐ E-Cig |
| If you do smoke, would you like to quit? | ☐ Yes ☐ No |
| In the past 4 weeks, how many drinks of wine, beer or other alcoholic beverage did you have, if any? | ☐ None<br>☐ 1 drink or less<br>☐ 2-5 per week<br>☐ 6-9 per week<br>☐ 10 or more per week |

## FALL RISK ASSESSMENT

| | |
|---|---|
| During the last 12 months, have you fallen 2 or more times? | ☐ Yes ☐ No |
| During the last 12 months, have you had a fall that resulted in an injury? | ☐ Yes ☐ No |
| Do you think that you are at high risk for falling? | ☐ Yes ☐ No |
| Do you use any assistive devices such as a walker, wheelchair or cane? | ☐ Yes ☐ No |
| Are you having trouble with walking or balance? | ☐ Yes ☐ No |
| Do you require assistance getting up from a sitting position? | ☐ Yes ☐ No |

## ISCHEMIC VASCULAR DISEASE (IVD)

| | |
|---|---|
| Were you discharged from a hospital for a Heart Attack, Coronary artery bypass grafting, or Percutaneous Coronary Intervention in the last 12 months or have an active diagnosis of Ischemic Vascular Disease? | ☐ Yes ☐ No |
| If you have one of the above are you taking ANY of the following medications Prasugrel (Effient), Aspirin, Clopidogrel (Plavix), Ticlopidine (Ticlid), Dipyridamole (Persantine), Ticagrelor (Brillinta)? | ☐ Yes ☐ No |

# Physician Review

The Following Information is being collected as part of the patient wellness exam. Please start by reviewing the Patient Questionnaire, with the special focus on the Depression Screening and Fall Risk screening which may require a follow-up visit.

Patient Name

## MEDICATION RECONCILIATION

*See Patient Questionnaire for more information

Please review medications for any additions or removals.

Select if applicable

- Medications reconciled in the medical record ***G8427***

## BMI

_____ Height

_____ Weight: kg lbs

_____ BMI Score

If BMI is ABOVE or BELOW normal, please create a BMI follow-up plan. Space is provided below

Select one:

AGES 65 years and older

- NORMAL (BMI between 23 to 29) ***G8420***
- ABOVE NORMAL (BMI > or = 30) ***G8417***
- BELOW NORMAL (BMI <23) ***G4818***

AGES 18 to 64

- NORMAL (BMI between 18.5 to 25) ***G8420***
- ABOVE NORMAL (BMI > or = 25) ***G8417***
- BELOW NORMAL (BMI <18.5) ***G4818***

## Vaccination & Immunizations

*See Patient Questionnaire for more information

Select one of each

Has patient received a Flu Immunization between 10/1/15 through 3/31/16?

_____ / ____ /_____
Month / Day / Year

Encounter for Immunization **(ICD-10) Z23**

- Administration of influenza vaccine ***G0008***
- Administered or previously received **G8482**
- Influenza vaccination not given: Medical Reasons **G8483**

Has patient ever received a Pneumonia Vaccination?

_____ / ____ /_____
Month / Day / Year

Encounter for Immunization **(ICD-10) Z23**

- Administration of pneumococcal vaccine **G0009**
- Pneumococcal vaccine not administered: Medical Reasons **G8865**
- Pneumococcal vaccination refusal **G8865**

## BLOOD PRESSURE

Select One

_____ / _____
Systolic Diastolic

- Normal (Systolic BP<=140mm/Hg) ***G8753***
- Above Normal ( Systolic BP >140mm/Hg ) ***G8752***
- Normal (Diastolic BP<=90mm/Hg) ***G8755***
- Above Normal (Diastolic BP>90mm/Hg ) ***G8754***

Does the patient have an active diagnosis of hypertension? If so, blood pressure levels must be under 140 / 90 to meet Hypertension measure.

If the patient does NOT have an active diagnosis of hypertension and blood pressure is between 120 / 80 and below 139 / 89, then one or more of the following lifetstyle modification must be documented and discussed with patient

- Weight Reduction
- Dietary Approaches to stop Hypertension (DASH) eating plan
- Dietary Sodium Restriction
- Increase Physical activity
- Moderation in alcohol (ETOH) consumption

If the patient does NOT have an active diagnosis of hypertension and blood pressure is greater than or equal to 140 / 90, then perform the following:

- Follow-up visit scheduled between 1 day and 4 weeks must be performed
- AND a recommend lifestyle modification outline in list above.

- Normal BP reading, no follow-up required ***G8783***
- Pre-hypertensive (120/80 – 139/89) or hypertensive (140/90) with follow-up ***G8950***

## COLONOSCOPY SCREENING

*See Patient Questionnaire for more information

| | Select one |
|---|---|
| Has this patient had a colorectal cancer screening performed in one of the following ways? | ☐ Fecal Occult blood test, immunoassay (within 1 year) ***G0328***<br>☐ Colorectal Cancer screening; flex sig (within 5 years) ***G0104***<br>☐ Colorectal Cancer screening; colonoscopy (within 10 years) ***G0105*** |

## DIABETES CONTROL & SCREENING

*See Patient Questionnaire for more information

| | Select one from each box |
|---|---|
| Is this patient 18 to 75 years of age with diabetes Type 1 or Type 2? | ☐ Yes<br>☐ No |
| Please report the patients most recent HbA1c level: _____ / _____ / _____ Date of screening | ☐ A1c<7% ***3044F***<br>☐ A1c 7-9% ***3045F***<br>☐ A1c>9% ***3046F*** |
| Has the patient had a retinal or dilated eye exam 1x in the last 12 months? | ☐ Dilated eye exam with interpretation by optometrist or ophthalmologist. Documented and reviewed. ***2022F***<br>☐ Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed ***2024F***<br>☐ Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed ***2026F***<br>☐ Low risk for retinopathy (no evidence of retinopathy in the prior year)* ***3072F***<br>☐ No |

## BREAST CANCER SCREENING (WOMEN ONLY)

*See Patient Questionnaire for more information

| | Select one |
|---|---|
| Skip measure if patient is not between 50 to 74 years of age at the beginning of 2016. | |
| Has this patient had a mammogram performed in the last 27 months with documented results discussed with the patient? _____ / _____ / _____ Date of last Mammogram | ☐ Yes ***G0202***<br>☐ No |

## DEPRESSION SCREENING

*See Patient Questionnaire for more information

| | Select one from each box |
|---|---|
| Was the patient screened for depression? | ☐ Yes ***G0444***<br>☐ No |
| If yes, did the patient score 5 or higher on the depression screening? | ☐ Yes<br>☐ No ***G8510*** |
| If yes, is the patient currently being treated for depression? | ☐ Yes<br>☐ No |
| If no, please describe the plan to address the depression. | ☐ Follow-Up plan documented ***G8431*** |

## TOBACCO SCREENING

*See Patient Questionnaire for more information

| | Select one |
|---|---|
| Please review tobacco use and provide counseling if necessary. | ☐ Smoking cessation counseling greater than 3 minutes ***G0436***<br>☐ Patient documented as a tobacco user and received cessation intervention ***G9458***<br>☐ Currently a tobacco non-user ***G9459*** |

## FALL RISK SCREENING

*See Patient Questionnaire for more information

| | Select one |
|---|---|
| Did the patient have 2 or more falls without injury or 1 or more falls with injury? | ☐ Yes ***1100F, 3288F***<br>☐ No ***1101F*** |
| If yes please provide fall risk counseling | ☐ Follow-up plan documented ***0518F*** |

| IVD<br>*See Patient Questionnaire for more information | Select one |
|---|---|
| Has the patient been discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) OR who had an active diagnosis of ischemic vascular disease (IVD), and who had documentation of use of aspirin or another antithrombotic<br><br>*Xarelto, Pradaxa, and Coumadin do not qualify as an antithrombotic for this measure. | ☐ LVEF < 40% diagnosed OR Moderately/Severely depressed left ventricular function ***G8934***<br>☐ ACE or ARB Prescribed ***G8935*** |

| HEART FAILURE | Select one from each box |
|---|---|
| Has the patient been diagnosed with heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40%? | ☐ LVEF >= 40% or documentation as normal or mildly depressed LVEF ***G8395***<br>☐ Code if LVEF < 40% in outpatient setting ***G8923***<br>☐ Code if LVEF < 40% discharged from hospital ***3021F*** |
| Is a beta-blocker prescribed? | If code 3021 selected above circle one below<br>☐ Beta-blocker prescribed ***G8450***<br>☐ Beta-blocker not prescribed for medical reasons ***G8451***<br>☐ Beta blocker therapy prescribed or currently taking ***4008F*** |

| CAD | Select one |
|---|---|
| Has the patient been diagnosed with Coronary Artery Disease and Diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% and been prescribed an ACE or ARB? | ☐ Yes ***4010F***<br>☐ No |

| STATIN THERAPY *NEW 2016 | Select one from each box |
|---|---|
| Is this patient 21 or older and diagnosed with clinical ASCVD? | ☐ Yes ***G9662***<br>☐ No |
| OR Is the patient 21 or older whose LDL-C was >= 190mg/DL | ☐ LDL-C less than 100mg/dL ***3048F***<br>☐ LDL-C 100-129 mg/dL ***3049F***<br>☐ LDL-C greater than or equal to 130 mg/dL ***3050F*** |
| OR is the patient aged 40-75 with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189mg/dL | ☐ LDL-C less than 100mg/dL ***3048F***<br>☐ LDL-C 100-129 mg/dL ***3049F***<br>☐ LDL-C greater than or equal to 130 mg/dL ***3050F*** |
| Was the patient prescribed a statin therapy? | ☐ Yes ***G9664***<br>☐ No |