empire® Healthcare

For Submission, Fax or Email to:

Christian Maronian
Director of Operations
CMaronian@EmpireCare.com
fax: (909) 494-7570
tel. (909) 554-4575

ANNUAL WELLNESS EXAMINATION FORM
(PRIMARY CARE)

DATE: _____

PATIENT NAME: _____ PATIENT ID #: _____ DOB: _____

PCP NAME: _____ GENDER: _____

PATIENT FORM

I. PATIENT HEALTH QUESTIONNAIRE (PHQ-2)

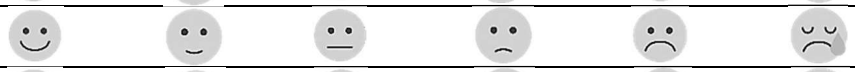
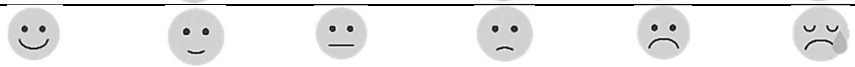
Over the last 2 weeks, how often have you been bothered by any of the following problems?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

MEDICAL ASSISTANT TO ADD THE SCORE *ADD ALL THE COLUMNS* _____ + _____ + _____

TOTAL SCORE ☐

II. MOOD ASSESSMENT

In the past 2 weeks, how did you feel about your: (circle one face each line)

SLEEP	
FAMILY AND FRIENDS	
STRESS	
INSPIRATION	
PHYSICAL ACTIVITY	

III. INCONTINENCE ASSESSMENT

In the past 12 months, have you had a problem with bowel (fecal) or bladder (urine) incontinence that is bothersome enough that you would like to know more about how it could be treated	☐ YES	☐ NO

IV. PAIN ASSESSMENT

DO YOU HAVE PAIN?	☐ YES ☐ NO	**IF YES, WHERE?**
INTENSITY (CIRCLE ONE)	0 1 2 3 4 5 6 7 8 9 10 *None* *Moderate* *Severe*	
HOW LONG HAVE YOU HAD THIS PAIN?		
WHAT DO YOU TAKE TO HELP?		
COMMENTS		

V. FRAIL ASSESSMENT

		SCORE
How much of the time during the past 4 weeks did you feel tired? (Fatigue)	**ALL OF THE TIME** **MOST OF THE TIME** SOME OF THE TIME A LITTLE OF THE TIME NONE OF THE TIME ***Response is either "ALL OF THE TIME" or "MOST OF THE TIME" = 1 →***	
By yourself and not using aids, do you have any difficulty walking up 10 steps without resting? (Resistance)	☐ **YES (1)** ☐ NO (0)	
By yourself and not using aids, do you have any difficulty walking several hundred yards? (Ambulation)	☐ **YES (1)** ☐ NO (0)	
Did a doctor ever tell you that you have: ***(Circle all that applies)***	Hypertension, Cancer (not minor skin cancer), Chronic Lung Disease, Congestive Heart Failure Diabetes, Heart Attack, Angina, Asthma, Arthritis, Stroke ***If total number of illnesses is 5 or more = 1 →***	
How much do you weigh with your clothes on but without shoes? ***[current weight]*** One year ago, how much did you weigh without your shoes and with your clothes on? ***[prior weight]***	_____Lbs. ***5% or more weight loss = 1→*** _____Lbs.	
MEDICAL ASSISTANT TO ADD THE SCORE	**TOTAL SCORE**	

PATIENT NAME: _____ PATIENT ID #: _____ DATE: _____ DOB: _____

PCP NAME: _____ GENDER: _____

PATIENT FORM

VI. PHYSICAL ACTIVITY ASSESSMENT

How often do you exercise per week? ☐ ≥ 5 days ☐ 4 - 3 days ☐ 2 - 1 day ☐ Seldom ☐ Never

VII. FUNCTIONAL ASSESSMENT

ACTIVITIES	INDEPENDENT (1 POINT each) *NO* supervision, direction or personal assistance	DEPENDENT (0 POINT each) *WITH* supervision, direction, personal assistance or total care
BATHING	Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area, or disabled extremity ☐	Needs help in bathing more than one part of the body getting out of the tub or shower. Requires total bathing ☐
DRESSING	Gets clothes from closets and drawers and puts on clothes and other garments complete with fasteners. May have help tying shoes. ☐	Needs help with dressing self or needs to be completely dressed. ☐
TOILETING	Goes to toilet, gets on and off, arranges clothes, cleans genital area without help. ☐	Needs help transferring to the toilet, cleaning self or uses bedpan or commode. ☐
TRANSFERRING	Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable. ☐	Needs help in moving from bed to chair or requires a complete transfer. ☐
CONTINENCE	Exercises complete self-control over urination and defecation. ☐	Is partially or totally incontinent of bowel or bladder. ☐
FEEDING	Gets food from plate into mouth without help. Preparation of food may be done by another person. ☐	Needs partial or total help with feeding or requires parenteral feeding. ☐
MEDICAL ASSISTANT TO ADD THE COLUMN	Total Score	

VIII. HISTORY

ALCOHOL / TOBACCO DRUGS RISK SCREEN	Have you ever smoked cigarettes, a pipe or cigars or chewed tobacco? ☐ Yes ☐ No *If Yes, how much and for how long?* _____ Do you ever drink alcohol? ☐ Yes ☐ No *If Yes, how much?* _____ Have you ever used any street drugs or taken prescription medications that were not prescribed for you? ☐ Yes ☐ No *If Yes, what drugs/meds?* _____ *For how long?* _____
PERSONAL HISTORY	Marital Status: ☐ Married ☐ Single ☐ Divorced *Do you have an Advance Directive* ☐ Yes ☐ No
PAST SURGICAL HISTORY *WHAT AND WHEN?*	

IX. CURRENT MEDICATIONS (Prescription, Over-the-Counter and Herbal medications). Attach a page if more space is needed

List your medication allergies:

#	MEDICATION	DOSE	HOW DO YOU TAKE IT?	WHEN DO YOU TAKE IT?
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

ANNUAL PHYSICAL EXAMINATION FORM
(PRIMARY CARE)

DATE: _____

PATIENT NAME: _____ **PATIENT ID #:** _____ **DOB:** _____

PCP NAME: _____ **GENDER:** _____

MEDICAL ASSISTANT FORM

☐ Score section **I. PATIENT HEALTH QUESTIONNAIRE (PHQ-2)**

TOTAL SCORE:		**0 - 2**	Negative. Reassess as needed
		≥ 3	Administer the full PHQ-9

Unable to complete the depression assessment due to:
☐ Unresponsive ☐ Uncooperative ☐ Severe Dementia ☐ Patient Refused
☐ Other (explain):_____

☐ See section **IV. PAIN ASSESSMENT** and check at least one appropriate:
- ☐ Pain Present (1125F)
- ☐ NO Pain present (1126F)
- ☐ Plan of care to address pain documented (0521F)

☐ Score section **V. FRAILITY ASSESSMENT**

TOTAL SCORE:		0	Robust health
		1 – 2	Pre-frail
		3 – 5	Frail

☐ Score section **VII. FUNCTIONAL ASSESSMENT (1170F)**

TOTAL SCORE:		6	High, Patient is independent
		0	Low, patient is very dependent

☐ **VITAL SIGNS**

BP	RR	PR	O2 Sat*	TEMP	HT	WT	BMI
			☐ RA ☐ with O2				

***If the O2 sat is measured with the patient on O2; if possible, remove the O2 for 15 or 20 minutes, and repeat the measurement on room air**

☐ Check the appropriate **BMI Code**

✓	ICD-10-CM Code	Adult BMI Range
	Z68.1	BMI less than 20
	Z68.20	BMI 20.0-20.9
	Z68.21	BMI 21.0-21.9
	Z68.22	BMI 22.0-22.9
	Z68.23	BMI 23.0-23.9
	Z68.24	BMI 24.0-24.9
	Z68.25	BMI 25.0-25.9
	Z68.26	BMI 26.0-26.9
	Z68.27	BMI 27.0-27.9

✓	ICD-10-CM Code	Adult BMI Range
	Z68.28	BMI 28.0-28.9
	Z68.29	BMI 29.0-29.9
	Z68.30	BMI 30.0-30.9
	Z68.31	BMI 31.0-31.9
	Z68.32	BMI 32.0-32.9
	Z68.33	BMI 33.0-33.9
	Z68.34	BMI 34.0-34.9
	Z68.35	BMI 35.0-35.9
	Z68.36	BMI 36.0-36.9

✓	ICD-10-CM Code	Adult BMI Range
	Z68.37	BMI 37.0-37.9
	Z68.38	BMI 38.0-38.9
	Z68.39	BMI 39.0-39.9
	Z68.41	BMI 40.0-44.9
	Z68.42	BMI 45.0-49.9
	Z68.43	BMI 50.0-59.9
	Z68.44	BMI 60.0-69.9
	Z68.45	BMI 70 and over

☐ Check the appropriate **Blood Pressure (BP) Code** *(SBP =Systolic BP; DBP =Diastolic BP)*

☐ SBP < 130 (3074F) ☐ SBP 130-139 (3075F) ☐ SBP 140 or over (3077F)
☐ DBP < 80 (3078F) ☐ DBP 80-89 (3079F) ☐ DBP 90 or over (3080F)

ANNUAL PHYSICAL EXAMINATION FORM
(PRIMARY CARE)

DATE: _____

PATIENT NAME: _____ **PATIENT ID #:** _____ **DOB:** _____

PCP NAME: _____ **GENDER:** _____

<Intentionally Left Blank>

ANNUAL PHYSICAL EXAMINATION FORM
(PRIMARY CARE)

DATE: _____

PATIENT NAME: _____ **PATIENT ID #:** _____ **DOB:** _____

PCP NAME: _____ **GENDER:** _____

PROVIDER FORM

COMPLETE THE FOLLOWING AS MARKED BY "☐"

☐ Review **PATIENT FORM** for important medical information about your patient
- ☐ Does the patient have **history or currently using Drug and/or Alcohol**?
- ☐ Check at least one appropriate "**Advance Care Plan**" code
  - ☐ Advanced Care Plan or other legal document present in medical record (1157F);
  - ☐ Advanced Care Plan discussion documented in medical record (1158F)
- ☐ Check both for a completed **Medication Review**
  - ☐ Medication List (1159F); ☐ Medication Review (1160F)

☐ Review **MEDICAL ASSISTANT FORM**
- ☐ Is the Patient on treatment for ***Depression***?

☐ **Fall Risk Assessment**

	YES	NO	If yes, specify reason	Comments
High Risk for Fall	☐	☐		
Cognitive Impairment	☐	☐		
Home assessment needed?	☐	☐		

☐ **Annual Physical Exam** completed

☐ Assess about Physical Activity and recommend an **Exercise Plan** (If needed, refer the patient our Exercise Councilor see *"Referral"* Section)

☐ **Preventive Care Screening**. See below

SCREENING CHECKLIST	YES (write date completed)	NO	N/A or Other Comment
Flu Vaccine in current season			
Pneumococcal vaccine: > 65 yrs. If given, please check which one: ☐ **Prevnar-13** ☐ **Prevnar-23**			
Colorectal Cancer Screening: > 50 yrs. ☐ Flex Sig in the last 5 years ☐ Colonoscopy in the last 10 years ☐ Fecal occult blood in current year			
Glaucoma test: > 65 yrs.			
Lab test for **LDL-C** in current year ☐ Current LDL-C value in current year is <100mg/dL			
MALES			
Prostate Cancer Screening: > 50 Yrs., Prostate specific antigen (PSA) test annually			
FEMALES			
Mammogram in current or prior year: 50-74 yrs.			
Bone Mineral Density Test annually or **on Osteoporosis Medication:** 65-85 yrs			
PATIENT WITH HYPERTENSION			
Most current **blood pressure** in current year is <140/90.			
PATIENT WITH CARDIOVASCULAR, CEREBROVASCULAR, OR PERIPHERAL ARTERIAL DISEASE			
Lab test for **LDL-C** in current year ☐ Current LDL-C value in current year is <70 mg/dl for secondary prevention			
Most current **blood pressure** in current year is <140/90.			
PATIENT WITH DIABETES			
Lab test for **HbA1c** in current year ☐ Most current HbA1c value is < 8.0%			
Diabetic Retinal eye exam in current year			
Lab test for **LDL-C** in current year ☐ Current LDL-C value in current year is <100mg/dL			
Most current **blood pressure** in current year is <140/90.			
Micro albumin Ratio annually			
eGFR annually			
PATIENT WITH RHEUMATOID ARTHRITIS			
Positive **Cyclic Citrullinated Peptide Antibody Assay (CCPA)**			
On **Disease-modifying anti-rheumatic drug (DMARD)**			
PATIENT WITH COPD			
Spirometry test to confirm diagnosis within 1 year of diagnosis			
PATIENT ON CERTAIN MEDICATIONS			
Serum **Potassium** and **Creatinine / BUN / eGFR** if taking one of the following: • *Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARB).* • *Digoxin* • *Diuretics*			

ANNUAL PHYSICAL EXAMINATION FORM
(PRIMARY CARE)

DATE: _____

PATIENT NAME: _____ **PATIENT ID #:** _____ **DOB:** _____

PCP NAME: _____ **GENDER:** _____

PROVIDER FORM

IMPRESSION / PLAN *(if in the progress notes, please submit a copy of the progress notes to us)*

DIAGNOSIS DESCRIPTION	STATUS OF DIAGNOSIS	PLAN OF CARE / CURRENT RX
	☐ Stable ☐ Declining ☐ End Stage	
	☐ Stable ☐ Declining ☐ End Stage	
	☐ Stable ☐ Declining ☐ End Stage	
	☐ Stable ☐ Declining ☐ End Stage	
	☐ Stable ☐ Declining ☐ End Stage	
	☐ Stable ☐ Declining ☐ End Stage	
	☐ Stable ☐ Declining ☐ End Stage	
DIABETIC DIAGNOSIS *if applicable*	**STATUS OF DIAGNOSIS**	**PLAN OF CARE / CURRENT RX**
☐ Diabetes	☐ Stable ☐ Declining ☐ End Stage	
☐ Diabetic Nephropathy	☐ Stable ☐ Declining ☐ End Stage	
☐ Diabetic Neuropathy	☐ Stable ☐ Declining ☐ End Stage	
☐ Diabetic Peripheral Angiopathy	☐ Stable ☐ Declining ☐ End Stage	
☐ Diabetic Retinopathy	☐ Stable ☐ Declining ☐ End Stage	
☐ CKD due to Diabetes	☐ Stable ☐ Declining ☐ End Stage	
☐ Diabetic PVD	☐ Stable ☐ Declining ☐ End Stage	
☐ ESRD due to Diabetes	☐ Stable ☐ Declining ☐ End Stage	
DIAGNOSIS DESCRIPTION	STATUS OF DIAGNOSIS	PLAN OF CARE / CURRENT RX
☐ Congestive Health Failure (CHF)		☐ Echo – EF:_____ ☐ ACE Inhibitor:_____
☐ Chronic Obstructive Pulmonary Disease (COPD)		☐ Spirometry Results: FEV:_____

Additional Comments

Print Provider Name _____ **Print Group Name** _____

Provider Signature _____ ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA**

Date _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**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
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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 difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐