HVHN ANNUAL WELLNESS VISIT

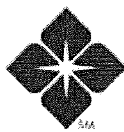
Reminder: Your Annual Wellness Visit is **NOT** your physical exam. It is a yearly meeting with your provider to discuss your health and to develop a personalized prevention plan.

√ Please fill out this Annual Wellness Visit form and bring it with you to your scheduled appointment.

√Please bring all medications with you to your Annual Wellness visit including: Prescription medications, over-the-counter medications, Vitamins and Supplements, and medications that you place on your body such as ointments or patches.

Patient's Last Name:	
Patient's First Name:	
Patient's Date of Birth:	**Today's Date:**

OFFICE USE ONLY	☐**Initial Preventative-IPPE (G0402)**	☐ **First AWV (G0438)**	☐**Subsequent AWV (G0439)**
Height:	**Weight:**	**BMI:**	**BP:**
Visual Acuity (IPPE Only):	**Right Eye:**	**Left Eye:**	**Both Eyes:**
☐ **Self-reported by patient**		☐ **Unable to obtain due to COVID-19 public health emergency**	



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HERITAGE VALLEY
HEALTH SYSTEM

Patient's Name: ______________________________ DOB:__________ Date: __________

OVERALL HEALTH: How would you rate the following?					
1) Overall Health	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
2) Physical Health (compared to last year.)	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
3) Eyesight (compared to last year.)	☐ Same	☐ Slightly Worse	☐ Much Worse		
4) Have you been screened for Glaucoma?	☐ Yes	☐ No			
5) Wears Corrective Lenses?	☐ Yes	☐ No			
6) Hearing (compared to last year.)	☐ Same	☐ Slightly Worse	☐ Much Worse		
7) Wears Hearing Aids?	☐ Yes	☐ No			
8) Do you have a dental problem that makes it hard for you to eat?	☐ Yes	☐ No			
9) Emotional Health (compared to last year.)	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
10) Pain (In the past 7 days)	☐ None (1126F)	☐ Very Mild(1125F)	☐ Mild(1125F)	☐ Mod (1125F)	☐ Severe (1125F)
10a) Pain Management Discussed if positive pain screen	☐ Yes (0521F)	☐ No			

EMOTIONAL HEALTH:		
1) Do you experience loneliness or isolation?	☐ Yes	☐ No
2) Do you currently have a diagnosis or are being actively treated for Depression? If yes, PHQ9 will be completed. If no, go to Question 3.	☐ Yes	☐ No
3) Over the past two weeks, how often have you been bothered by any of the following problems?		
Felt down, depressed or hopeless? ☐ Not at all (0) ☐ Several Days (1) ☐ More than Half the Days (2) ☐ Nearly Every Day (3)		
Had little or no interest or pleasure in doing things? ☐ Not at all (0) ☐ Several Days (1) ☐ More than Half the Days (2) ☐ Nearly Every Day (3)		
Score: _______ If overall score is >= 3, complete PHQ-9 Depression Screening Questionnaire.		

OFFICE USE ONLY:

Depression Screening: ☐ Negative – PHQ2 <=2 or PHQ9 (when done PHQ2 > =3) <=9 (G8510)
☐ Positive – PHQ9 >= 10 (providers need to have a plan of care for positive screen (G8431)

Depression Monitoring:
☐ Remission – PHQ9 <=4 (G8510)
☐ Active Depression – PHQ9 >=5 (providers should address Plan of Care) (G8431)

Patient's Name: ____________________ DOB:__________ Date: __________

BROKEN BONES/FALLS:		
1) Have you broken a bone?	☐ Yes	☐ No
2) Have you had a Bone Mineral Density test/DEXA?	☐ Yes	☐ No
3) Do you use a cane or walker?	☐ Yes	☐ No
4) Have fallen within the past year?	☐ Yes	☐ No
4a) ☐ No falls OR one fall without an injury (1101F)		
4b) ☐ 1 fall with an injury or 2 or more falls (1100F)		
5) Fall Risk Plan of Care Discussed if 1 fall with injury or 2 or more falls?	☐ Yes (0518F)	☐ No
6) Do currently use multiple medications (More than 9 medications)	☐ Yes	☐ No
7) Do you use any sedatives?	☐ Yes	☐ No
8) Do you have any mobility impairment?	☐ Yes	☐ No
9) Do you use alcohol?	☐ Yes	☐ No
10) Are you deconditioned?	☐ Yes	☐ No
11) Do you have a visual impairment?	☐ Yes	☐ No
12) Antidepressant Use?	☐ Yes	☐ No
13) Do you get lightheaded when you change position?	☐ Yes	☐ No
14) Antihypertensive Use?	☐ Yes	☐ No
15) Up&Go Test Unsteady/ >30sec?	☐ Yes	☐ No
Comments:		

BLADDER/BOWEL:		
1) In the past six months, have you accidentally leaked urine?	☐ Yes	☐ No
1a) Urine incontinence assessed if present or absent	☐ Yes (1090F)	☐ No
1b) Urine incontinence Plan of Care if Positive (0509F)	☐ Yes (0509F)	☐ No
2) Do you have problems with loss of bowel control?	☐ Yes	☐ No
Comments:		

IMMUNIZATIONS:		
1) Have you had a Flu shot within the past year?	☐ Yes	☐ No
2) Have you had a Pneumonia shot?	☐ Yes	☐ No
3) Have you Had a Shingles shot?	☐ Yes	☐ No
4) When was your last Tetanus/Diphtheria Shot?	Date: ______________	
5) When was your last COVID booster?	Date: ______________	

PREVENTATIVE SCREENINGS:		
1) Have you had a Mammogram/Breast Cancer Screening (Women Only)? Date:	☐ Yes	☐ No
2) Have you had a Prostate Cancer Screening (Men Only)? Date:	☐ Yes	☐ No
3) Have you had a Colon Cancer Screening? Date:	☐ Yes	☐ No
4) Have you had a Cholesterol Screening? Date:	☐ Yes	☐ No

Patient's Name: ______________________________ DOB:__________ Date: __________

HOME SAFETY:		
1) Does your home have working smoke alarms?	☐ Yes	☐ No
2) Does your home have a working carbon monoxide detector?	☐ Yes	☐ No
3) Do you have trouble with stairs or have no stair rails inside or outside your home?	☐ Yes	☐ No
4) Do you have hazards inside your home such as a lack of grab bars in the bathroom, loose rugs, poor lighting, uneven floors, household clutter, or unfamiliar surroundings?	☐ Yes	☐ No
Comments:		
ACTIVITIES OF DAILY LIVING:		
1) Do you get out of bed by yourself?	☐ Yes	☐ No
2) Do you dress yourself?	☐ Yes	☐ No
3) Do you make your own meals?	☐ Yes	☐ No
4) Do you do your own shopping?	☐ Yes	☐ No
5) Do you bathe yourself?	☐ Yes	☐ No
6) Do you do your laundry/housekeeping?	☐ Yes	☐ No
7) Do you manage your money, pay your bills and track your expenses?	☐ Yes	☐ No

NUTRITION:	
1) Any Food/Dietary restrictions?	Please list:______________________________
2) Any concerns about nutrition?	Please list:______________________________
3) Weight in the past 6 months, have you lost or gained 10 lbs without trying?	Comments:

3) Are you worried that your food will run out before you have money to buy more?	☐ Yes	☐ No

LIFESTYLE CHOICES:		
1) Do you currently smoke or use tobacco products?	☐ Yes	☐ No
2) Have you smoked or used other tobacco products in the past?	☐ Yes	☐ No
3) If yes, when did you stop?		
4) Do you use Medical Marijuana?	☐ Yes	☐ No
5) Do you drink alcohol?	☐ Yes	☐ No
6) If yes, how many drinks/week?		
7) Do you use illegal drugs?	☐ Yes	☐ No
7a) If yes, what substances?		
8) Do you drive?	☐ Yes	☐ No
9) Do you wear seatbelts?	☐ Yes	☐ No
10) Describe your level of physical activity:		

Patient's Name: ____________________________ DOB:__________ Date: __________

ADVANCED DIRECTIVES:		
1) Have you decided who would speak for you and make health care treatment choices for you if you became ill and could not make them for yourself?	☐ Yes	☐ No
2) Have you spoken to that person about your choices?	☐ Yes	☐ No
3) Have you completed a written Advance Directive, that is, a Living Will and/or Health Care Power of Attorney?	☐ Yes	☐ No
4) Do you have someone who helps you manage your healthcare, like a friend or family member?	☐ Yes	☐ No
5) If yes, please provide their Name: ____________________ Address: ____________________ Phone Number: ____________________		
☐ Advanced Directive Care Plan Discussed and Documented (1123F)		
☐ Patient was Unwilling and/or Unable to Provide Care Plan or Define Surrogate (1124F)		

You have a partner in health.

Thank you for completing this checklist. You should feel good about being proactive! Following through with preventative care is one of the best things you can do for your well-being. Your health is important. Heritage Valley is here to help protect it with resources, information, and the personal support you need.

OFFICE USE ONLY:		
Is there any decline in cognitive function or memory deficit through direct observation?	☐ Yes	☐ No
If yes, please indicate further evaluation and interventions planned: ☐ MiniCog Completed ☐ MMSE Completed ☐ Other Comments:		

OFFICE USE ONLY:
☐ See Patient's Personal Preventative Wellness Plan &Counseling and Referrals/Plan of Care Recommendations Sheet
☐ The patient has verbally consented to participate in the communication technology-based service.
☐ The service was performed using an interactive, real-time telehealth session which included both audio and video. Patient location: ____________________ Provider location: ____________________
☐ The service was performed using telephone, audio-only. A video connection with the patient is not possible.
Reviewed by/Credentials: ______________________________ Date: __________
Provider Signature: ______________________________ Date: __________

****Scan Paper Copy of Annual Wellness Visit into Patient's Electronic Health Record.**
****Scan Paper Copy of Patient's Personal Preventative Wellness Plan & Counseling and Referrals/Plan of Care Recommendations Sheet into Patient's Electronic Health Record.**