MEDICARE PREVENTIVE PHYSICAL EXAM

Today's Date _____

☐ Initial Preventive Physical Exam (Welcome to Medicare Physical)	☐ Initial annual wellness visit	☐ Subsequent annual wellness visit	☐ Other
Patient name	Medical record #		Date of birth
Staff conducting initial intake	Date of last exam		Medicare B eligibility date
Language or other communication barriers: (describe)			Sex / LMP
Interpreter or other accommodation provided today: (describe)			Gravida/ para / Year of menopause

Vital signs	Ht	Wt	BMI	Waist	BP	Temp	P/R

SOCIAL HISTORY

Tobacco ☐ Current Type: Freq: ☐ 2nd hand ☐ Never ☐ Prior use Quit date:

ETOH ☐ Never ☐ Occasional ☐ Daily History of ETOH: (describe)

Caffeine ☐ Never ☐ Occasional ☐ Daily

Drug abuse ☐ Never ☐ Occasional ☐ Daily ☐ Prior use Quit date:
History of drug abuse: (describe)

Occupation | Exercise type/frequency

Home environment ☐ Private home ☐ Assisted living ☐ Other: (describe)

FAMILY HISTORY
use ✓ to indicate positive history

	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart disease									
Stroke									
Kidney disease									
Obesity									
Genetic disorder									
Alcoholism									
Liver disease									
Depression or manic depressive disorder									
Colon or rectal cancer									
Breast cancer									
Other cancer									
Other: _____									

Patient Name _____ Today's Date _____

MEDICAL HISTORY				
Hospital visits since last office visit/reason	Facility	Attending physician	Date of hospital visit	Past surgeries (include date and description of any complications)

ALLERGY LIST	
Allergies	Type of reaction

MEDICATION LIST if noted elsewhere in chart, indicate location: _____					
Herbals, supplements, OTC drugs, substances of abuse	Date started	Date discon-tinued	Rx meds, dose, frequency, route	Date started	Date discon-tinued

PROBLEM LIST				
Chronic problems	Date added	Managing physician (if other)	Date updated	Initial

continued ➤

Patient Name _____ Today's Date _____

PROBLEM LIST continued				
Acute problems (R=resolved)	Date added	Managing physician (if other)	Date updated	Initial

OTHER PHYSICIANS AND PROVIDERS OF CARE this documentation not required for IPPE		
Name & specialty/provider type	Type of care	Date discontinued

→ Physician/other provider sign here to indicate review/notation of pertinent history: _____

DEPRESSION SCREENING		
1. Over the past two weeks, has the patient felt down, depressed or hopeless?	☐ Yes	☐ No
2. Over the past two weeks, has the patient felt little interest or pleasure in doing things?	☐ Yes	☐ No

FUNCTIONAL ABILITY/SAFETY SCREENING		
1. Was the patient's timed Up & Go test unsteady or longer than 30 seconds?	☐ Yes	☐ No
2. Does the patient need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money?	☐ Yes	☐ No
3. Does the patient's 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
Hearing evaluation:		
A "yes" response to any of the above questions regarding depression or function/safety should trigger further evaluation.		

EVALUATION OF COGNITIVE FUNCTION this documentation not required for IPPE
Mood/affect
Appearance
Family member/caregiver input

Patient Name _____ Today's Date _____

VISION EXAMINATION
Visual acuity: L _____ R _____

ELECTROCARDIOGRAM REFERRAL OR RESULT if performed/ordered (covered benefit for IPPE)

ADVICE/REFERRALS based on history, exam and screening (including risks, interventions underway or planned, and benefits)

POTENTIAL RECOMMENDATIONS NOT COVERED AS MEDICARE PART B PREVENTIVE SERVICES this documentation not required for IPPE *Patients should contact their Part-D plan for information on preventive vaccines benefits.*	
Varicella vaccine	Aspirin therapy
Zoster vaccine (once)	Calcium supplement
Tdap vaccine (10 years)	Social services
Td vaccine (10 years)	Dietary counseling
MMR vaccine	
Meningococcal vaccine	
Hep A vaccine	

HANDOUTS REVIEWED AND DISCUSSED WITH PATIENT

continued ➤

Patient Name _____ Today's Date _____

Create two copies of this page: One for your charts and one to give to your patient.

COUNSELING AND REFERRAL OF OTHER PREVENTIVE SERVICES

(*Italic type* indicates deductible and co-insurance are waived.)

SERVICE	LIMITATIONS	RECOMMENDATION	SCHEDULED
Vaccines • Pneumococcal (once after 65) • Influenza (annually) • Hepatitis B (if medium/high risk)	Medium/high risk factors: End-stage renal disease Hemophiliacs who received Factor VIII or IX concentrates Clients of institutions for the mentally retarded Persons who live in the same house as a HepB virus carrier Homosexual men Illicit injectable drug abusers		
Mammogram (biennial age 50-74)	Annually (age 40 or over)		
Pap and pelvic exams (up to age 70 and after 70 if unknown history or abnormal study last 10 years)[1]	Every 24 months except high risk		
Prostate cancer screening (annually to age 75) Digital rectal exam (DRE) *Prostate specific antigen (PSA)*	Annually (age 50 or over), DRE not paid separately when covered E/M service is provided on same date		
Colorectal cancer screening (to age 75) • *Fecal occult blood test (annual)* • *Flexible sigmoidoscopy (5y)* • *Screening colonoscopy (10y)* • Barium enema			
Diabetes self-management training (no USPSTF recommendation)	Requires referral by treating physician for patient with diabetes or renal disease. 10 hours of initial DSMT sessions of no less than 30 minutes each in a continuous 12-month period. 2 hours of follow-up DSMT in subsequent years.		
Bone mass measurements (age 65 & older, biennial)	Requires diagnosis related to osteoporosis or estrogen deficiency. Biennial benefit unless patient has history of long-term glucocorticoid tx or baseline is needed because initial test was by other method.		
Glaucoma screening (no USPSTF recommendation)	Diabetes mellitus, family history African American, age 50 or over Hispanic American, age 65 or over		
Medical nutrition therapy for diabetes or renal disease (no recommended schedule)	Requires referral by treating physician for patient with diabetes or renal disease. Can be provided in same year as diabetes self-management training (DSMT), and CMS recommends medical nutrition therapy take place after DSMT. Up to 3 hours for initial year and 2 hours in subsequent years.		

Patient Name _____ Today's Date _____

SERVICE	LIMITATIONS	RECOMMENDATION	SCHEDULED
Cardiovascular screening blood tests (every 5 years) • Total cholesterol • High-density lipoproteins • Triglycerides	Order as a panel if possible.		
Diabetes screening tests (at least every 3 years, Medicare covers annually or at 6-month intervals for prediabetic patients) • Fasting blood sugar (FBS) or glucose tolerance test (GTT)	Patient must be diagnosed with one of the following: • Hypertension • Dyslipidemia • Obesity (BMI ³30 kg/m2) • Previous elevated impaired FBS or GTT ... or any two of the following: • Overweight (BMI ³25 but <30) • Family history of diabetes • Age 65 years or older • History of gestational diabetes or birth of baby weighing more than 9 pounds		
Abdominal aortic aneurysm screening (once) • Sonogram	Patient must be referred through IPPE and not have had a screening for abdominal aortic aneurysm before under Medicare. Limited to patients who meet one of the following criteria: • Men who are 65-75 years old and have smoked more than 100 cigarettes in their lifetime • Anyone with a family history of abdominal aortic aneurysm • Anyone recommended for screening by the USPSTF		
HIV screening (annually for increased risk patients) • HIV-1 and HIV-2 by EIA, ELISA, rapid antibody test or oral mucosa transudate	Patient must be at increased risk for HIV infection per USPSTF guidelines or pregnant. Tests covered annually for patients at increased risk. Pregnant patients may receive up to 3 tests during pregnancy.		
Smoking cessation counseling (up to 8 sessions per year) • Counseling greater than 3 and up to 10 minutes • Counseling greater than 10 minutes	Patients must be asymptomatic of tobacco-related conditions to receive as a preventive service.		
Subsequent annual wellness visit	At least 12 months since last AWV		

Physician's signature: _____ Date: _____

1. Recommendation of American Cancer Society; see http://www.uspreventiveservicestaskforce.org/3rduspstf/cervcan/cervcanrr.htm#clinical for more information.

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