

**ANNUAL HEALTH ASSESSMENT FORM**

Date:	Name:	DOB:	Health Plan:
Temp:	BP:                      HR:	Ht:                      Wt:	BMI:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Allergies:	
PCP:		PCP Address:	

Measurement Qualification/codes	Description	Codes in ()	Bolded are control
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✓ **FOR ALL THE SENIOR PATIENTS include order or capture date no pending please**

1. Flu Vaccine (All ages yearly)	Date of vaccination: ____/____/20__ (G0008) or previously (G8482)
2. Pneumococcal Vaccine (Age > 60)	Date of vaccination: ____/____/20__ (G0009) or previously (4040F)
3. Colon Cancer Screening (Age 50-75) Colonoscopy Q10 years or Sigmoidoscopy Q5 years or FOBT annually ICD- Z12.11	Check one <input type="checkbox"/> Colonoscopy (G0105) <input type="checkbox"/> Sigmoidoscopy (G0104), <input type="checkbox"/> FOBT (G0328) Screening date: ____/____/____, Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Polyp Or <input type="checkbox"/> Not applicable (due to h/o Colon Cancer or s/p colectomy). Approximate dates are acceptable but year is mandatory. Please record date in chart.
4. Female Breast Cancer Screening (Age 40-74) Q2 yrs, ICD- Z12.31	Mammogram date: ____/____/____, (G0202) Or <input type="checkbox"/> Not applicable due to (s/p bilateral mastectomy or history of Breast CA)
5. HTN control, last BP < 140/90 mm Hg (Age 18-85, Q yr.) (3074F-3078F)	Last BP reading: ____/____ mm Hg, Date measured: ____/____/20__ Must have diagnosis of HTN on progress note.
6. BMI/ Obesity (Age 18-74 annually)	BMI = ____ Date: ____/____/20__ (3008F)      Z68.____
7. Osteoporosis: Females Age 65-85 years, who suffered a fracture	Bone Density Scan Date: ____/____/____
Diagnosis for RA Verified? No Yes Exclude due to diagnosis of HIV Positive.	If yes: Prescribed or current disease-modifying antirheumatic drug (DMARD) Date: ____/____/20__

✓ **Care of Older Adults (COA)**

8. Medication List	<input type="checkbox"/> YES      Date: ____/____/20__ <input type="checkbox"/> <b>CODE: 1159F</b>
9. Medication List Reviewed	<input type="checkbox"/> YES      Date: ____/____/20__ <input type="checkbox"/> <b>CODE: 1160F</b>
10. Pain Assessment: Does the member have any pain?	<input type="checkbox"/> YES      Date: ____/____/20__ <input type="checkbox"/> <b>CODE: 1125F</b> Location: _____ <input type="checkbox"/> NO      Date: ____/____/20__ <input type="checkbox"/> <b>CODE: 1126F</b>
11. Functional Status Assessment: Activities of daily living were assessed	<input type="checkbox"/> YES      Date: ____/____/20__ <input type="checkbox"/> <b>CODE: 1170F</b>
12. Advance Directives on file? If not, discussed with patient:	<input type="checkbox"/> YES      Date: ____/____/20__ <input type="checkbox"/> <b>CODE: 1157F</b> <input type="checkbox"/> YES      Date: ____/____/20__ <input type="checkbox"/> <b>CODE: 1158F</b>

✓ **Does the member have DIABETES? if not skip, bolded codes are controlled ages 18-75 annually, mark the date test captured or ordered, no pending**

13. Last LDL LESS THAN 100 mg/dl (3048F-3050F)	Last LDL: ____ mg/dl, Lab date: ____/____/20__
14. Diabetic Retina Exam (2022F-2026F, 2033F, 3072F)	Date performed by optometrist or ophthalmologist: ____/____/20__ Optometrist or Ophthalmologist Name: _____
15. Last HgA1C LESS THAN 9.0% (3044F, 3051F, 3052F, 3046F)	Last HgA1C: ____ %, Lab date: ____/____/20__
16. Microalbuminuria (3061F, 3062F) Or is pt. on an ACE or ARB	Lab date: ____/____/20__, Result: <input type="checkbox"/> (+) <input type="checkbox"/> (-) Or <input type="checkbox"/> Yes on ACE or ARB _____ Date: ____/____/20__
17. Blood pressure reading LESS THAN 140/90 mm Hg. (3074F-3078F)	Last BP reading:: ____/____ mm Hg, Date measured: ____/____/20__

I certify that I have performed all the services listed above and on the next page as they are applicable to this member and all the results have been documented in the member's chart. I understand that if I submit information for a measure that is incomplete it will not be counted by PCAC IPA and associated Health Plan.

⇒ **Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Pt. Name: \_\_\_\_\_

Pt. DOB: \_\_\_\_\_

✓ <b>Medication Management</b>		
18. Statin Treatment for Diabetes (Age 40-75, Q1 Yr) (Only for members with DM)	Is member currently taking a statin? <input type="checkbox"/> YES <input type="checkbox"/> NO (If Member <u>has DM</u> , member should be on statin) QT 90-100 x 3 Prescribed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Statins use inappropriate for this member <input type="checkbox"/> YES <input type="checkbox"/> NO
19. Statin Treatment for Cardiovascular Disease (Males Age 21-75, & Females Age 40-75, Q1 Yr)	Is member currently on a statin? <input type="checkbox"/> YES <input type="checkbox"/> NO (Only for members with CVD) QT 90-100 x 3 Prescribed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Statins use inappropriate for this member <input type="checkbox"/> YES <input type="checkbox"/> NO
20. RAS Antagonists Adherence (Age 18 & Older, Q1 Yr)	Has this member been educated? QT 90-100 x 3 Prescribed? <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. Oral Diabetic Medication (Age 18 & Older)	Has this member been educated? QT 90-100 x 3 Prescribed? <input type="checkbox"/> YES <input type="checkbox"/> NO	
22. Statin Adherence (Age 18 & Older, Q1 Yr)	Has this member been educated? QT 90-100 x 3 Prescribed? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**FUNCTIONAL STATUS ASSESSMENT:**

**CODE 1170F**

- ✓ Transportation: Drives self  Bus  Taxi  Driven by others
- ✓ Ability to administer medication to self: Yes  No
- ✓ Housework: Yes  No
- ✓ Ability to prepare and serve own food: Yes  No
- ✓ Grocery shopping: Yes  No
- ✓ Laundry: Yes  No
- ✓ Ambulation: Walks on own  Walks with assistance  Walker  Cane  Partial with dependence
- ✓ Completely dependent  Bedridden

**COGNITIVE FUNCTION ASSESSMENT:**

- ✓ Oriented and alert: Yes  No
- ✓ Memory deficit: Yes  No
- ✓ Immediate recall: Yes  No

PHQ9 Depression screening questionnaire	Date ____/____/2020	Not at all 0	< week 1	> week 2	Daily 3
<b>Over the past 14 days, how often have you experienced any of the following problems?</b>					
1. Feeling down, depressed, hopeless, and helpless.					
2. Having little interest or pleasure in doing daily activities.					
3. Feeling tired or having a little or no energy.					
4. Trouble falling or staying asleep, or sleeping too much.					
5. Trouble concentrating or doing things such as reading the newspaper or magazines or TV.					
6. Feeling bad about yourself, Thinking that you're a failure or have let yourself or your family down.					
7. Poor appetite or over eating.					
8. Moving or speaking slowly than others that have been noticed. Or being restless, fidgety and moving around more than usual.					
9. Thoughts that you are better off dead or hurting yourself in some way.					

Total \_\_\_\_\_ / 27

0-4 no depression    5-9 mild depression    10-14 Moderate depression    15-19 Moderate to severe depression    20-27 Severe depression

**PHQ9 Score <10 \_\_\_\_\_ > \_\_\_\_\_**

⇒ **Provider Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Pt. Name: \_\_\_\_\_

Pt. DOB: \_\_\_\_\_

**Chief Complaints / History of Present illness:**

\_\_\_\_\_  
 \_\_\_\_\_

**Current Medications & dosage:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family History:**

	Father	Mother	Children	Siblings	Grandparents
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Past Medical History:**

\_\_\_\_\_

**Social History:**

Drug Abuse/Dependence \_\_\_\_\_  Alcohol Abuse/Dependence \_\_\_\_\_  
 Smoking:  Past \_\_\_\_\_  Current, # of pack \_\_\_\_\_  
 Sexual History \_\_\_\_\_  High-risk lifestyle \_\_\_\_\_

**Surgical History:**

Procedure	Reason for Procedure	Date	Surgeon or facility
_____	_____	_____	_____
_____	_____	_____	_____

**Review of Systems:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Providers involved with care specialists/suppliers:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Physical Exam:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

WBC: \_\_\_\_\_ Hgb: \_\_\_\_\_ Hct: \_\_\_\_\_  
 Plt: \_\_\_\_\_ GFR: \_\_\_\_\_ HgA1c: \_\_\_\_\_  
 Date of lab: \_\_\_\_/\_\_\_\_/\_\_\_\_

Code if present:	<input type="checkbox"/> Active/stable <input type="checkbox"/> Acute <input type="checkbox"/> Declining <input type="checkbox"/> Resolved	Plan: Current Rx
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Code if present:	<input type="checkbox"/> Active/stable <input type="checkbox"/> Acute <input type="checkbox"/> Declining <input type="checkbox"/> Resolved	Plan: Current Rx
<b>Provider Signature and Credential</b>		(Check one) <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other Date: _____

⇒ **Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Pt. Name: \_\_\_\_\_

Pt. DOB: \_\_\_\_\_

Code if present:		<input type="checkbox"/> Active/stable <input type="checkbox"/> Acute <input type="checkbox"/> Declining <input type="checkbox"/> Resolved	Plan: Current Rx
<u>Provider Signature and Credential</u>		(Check one) <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other Date:	

⇒ Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_