Primary Care
ASSOCIATES OF CALIFORNIA
PCAC

Annual Health Assessment Form

Patient Name		DOB	Health Plan
Temp	BP HR	Ht Wt	BMI
Gender ☐ Male ☐ Female	Allergies		
PCP		Martial Status	Education Level
Immunization Records ☐ ACIP ☐ Yes ☐ No	Work History		
Measurement Qualification/Codes	Description	Codes in ()	Bolded are Control

For All the Senior Patients (Include Order or Capture Date. No Pending Please.)			
1. Flu Vaccine (All Ages Yearly)	Vaccination Date: ____ / ____ / 20 ____ (G0008 or previously (G8482)		
2. Pneumococcal Vaccine (Age > 60)	Vaccination Date: ____ / ____ / 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: ☐ Colonoscopy (G0105) ☐ Sigmoidoscopy (G0104) ☐ FOBT (G0328) Screening Date: ____ / ____ / 20 ____ , Results: ☐ Normal ☐ Abnormal ☐ Not applicable (Due to h/o Colon Cancer or s/p colectomy) ☐ Polyp Or **Approximate 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: ____ / ____ / 20 ____ , (G0202) or ☐ 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: ____ / ____ / 20 ____		
8. Diagnosis for RA Verified? ☐ Yes ☐ No Exclude due to diagnosis of HIV Positive.	If yes: Prescribed or current disease-modifying anti rheumatic drug (DMARD) Date: ____ / ____ / 20 ____		

Care of Older Adults (COA)			
9. Medication List	☐ Yes	Date: ____ / ____ / 20 ____	☐ Code: **1159F**
10. Medication List Reviewed	☐ Yes	Date: ____ / ____ / 20 ____	☐ Code: **1160F**
11. **Pain Assessment** Does the member have any pain?	☐ Yes Location: ____ ☐ No	Date: ____ / ____ / 20 ____ Date: ____ / ____ / 20 ____	☐ Code: **1125F** ☐ Code: **1126F**
12. **Functional Status Assessment** Activities of daily living were assessed	☐ Yes	Date: ____ / ____ / 20 ____	☐ Code: **1170F**
13. **Advance Directives on file?** If not, discussed with patient:	☐ Yes ☐ Yes	Date: ____ / ____ / 20 ____ Date: ____ / ____ / 20 ____	☐ Code: **1157F** ☐ Code: **1158F**

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: _____

Patient Name: _____ DOB: _____

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		
14. Last LDL LESS THAN 100 mg/dl (3048F-3050F)	Last LDL: _____ mg/dl Lab Date: _____ / _____ / 20 _____	
15. Diabetic Retina Exam (2022F-2026F, 2033F, 3072F)	Date performed by optometrist or ophthalmologist: _____ / _____ / 20 _____ Optometrist or Ophthalmologist Name: _____	
16. Last HgA1C LESS THAN 9.0% (3044F, 3051F, 3052F, 3046F)	Last HgA1C: _____ % Lab Date: _____ / _____ / 20 _____	
17. Microalbuminuria (3061F, 3062F) Or is pt. on an ACE or ARB	Lab Date: _____ / _____ / 20 _____ ☐ **(+)** ☐ **(-)** OR ☐ Yes on ACE or ARB _____ Date: _____ / _____ / 20 _____	
18. Blood pressure reading LESS THAN 140/90mm Hg, (3074F-3078F)	Last BP Reading: _____ / _____ mm Hg Date Measured: _____ / _____ / 20 _____	
Medication Management		
19. Statin Treatment for Diabetes (Age 40-75, Q1 Yr) (Only for members with DM)	Is member currently taking a statin? ☐ Yes ☐ No (If Member **has DM**, member should be on statins) QT 90-100 x 3 Prescribed? ☐ Yes ☐ No	Statins use inappropriate for this member? ☐ Yes ☐ No
20. Statin Treatment for Cardiovascular Disease (Males Age 21-75, & Females Age 40-75, Q1 Yr)	Is member currently on a statin? ☐ Yes ☐ No (Only for members with CVD) QT 90-100 x 3 Prescribed? ☐ Yes ☐ No	Statins use inappropriate for this member? ☐ Yes ☐ No
21. RAS Antagonists Adherence (Age 18 & Older, Q1 Yr)	Has this member been educated? ☐ Yes ☐ No QT 90-100 x 3 Prescribed? ☐ Yes ☐ No	
22. Oral Diabetic Medication (Age 18 & Older)	Has this member been educated? ☐ Yes ☐ No QT 90-100 x 3 Prescribed? ☐ Yes ☐ No	
23. Statin Adherence (Age 18 & Older, Q1 Yr)	Has this member been educated? ☐ Yes ☐ No QT 90-100 x 3 Prescribed? ☐ Yes ☐ No	

Functional Status Assessment

1. Transportation: ☐ Drives Self ☐ Bus ☐ Taxi ☐ Driven by Others
2. Ability to administer medication to self: ☐ Yes ☐ No
3. Housework: ☐ Yes ☐ No
4. Ability to prepare and serve own food: ☐ Yes ☐ No
5. Grocery Shopping: ☐ Yes ☐ No
6. Laundry: ☐ Yes ☐ No
7. Ambulation: ☐ Walks on Own ☐ Walks w/ Assistance ☐ Walker ☐ Cane ☐ Partial w/ Dependence ☐ Completely Dependent ☐ Bedridden

Cognitive Function Assessment

1. Oriented and alert: ☐ Yes ☐ No
2. Memory Deficit: ☐ Yes ☐ No
3. Immediate recall: ☐ Yes ☐ No

Provider Signature: _____ Date: _____

Patient Name: _____ DOB: _____

PHQ9 Depression Screening Questionnaire

Over the past 14 days, how often have you experienced any of the following problems? Date: _____

	Not at all 0	< Week 1	> Week 2	Daily 3
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.	○	○	○	○

0–4	5–9	10–14	15–19	20–27	
No Depression	Mild Depression	Moderate Depression	Moderate to Severe Depression	Severe Depression	**Total:** 0 **/27**

PHQ9 Score < 10 _____ > _____

Chief Complaints/History of Present Illness

_____

_____

_____

Current Medications & Dosage

_____

_____

_____

_____

_____

_____

_____

_____

Family History

	Father	Mother	Children	Siblings	Grandparents
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐

Past Medical History

_____

_____

Social History

Education Provided

☐ Drug Abuse/Dependence _____ ☐ Alcohol Abuse/Dependence _____ ☐

☐ Smoking: ☐ Past _____ ☐ Current, # of packs _____ ☐

☐ Pap Smear ☐ Sexual History _____ ☐ High Risk Lifestyle _____ ☐

☐ Nutrition Counseling

Provider Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Surgical History

Procedure	Reason for Procedure	Date	Surgeon/Facility

Review of Systems

General Appearance

Eyes

Ear, Nose, Mouth, Throat & Neck

Cardiovascular

Respiratory

Gastrointestinal

Urinary

Skin

Neurological

Lymphatic

Physical Exam

Prostate Cancer Screening: _____ Date: ____ / ____ / 20 ____

Lung Cancer Screening: _____ Date: ____ / ____ / 20 ____

Cervical/Vaginal Cancer Screening: _____ Date: ____ / ____ / 20 ____

STD Screening: _____ Date: ____ / ____ / 20 ____

TB Test: _____ Date: ____ / ____ / 20 ____

Abdominal Aneurysm Screening: _____ Date: ____ / ____ / 20 ____

HEP B Screening: _____ HEP C Screening: _____

WBC: _____ Hgb: _____ Hct: _____

Plt: _____ GFR: _____ HgA1c: _____

PSA: _____ Date of Lab: ____ / ____ / 20 ____

Providers Involved with Care Specialists/Suppliers

Provider Signature: _____ Date: _____

Patient Name: ______________________________ DOB: ______________

Code if Present:	☐ Active/Stable ☐ Acute ☐ Declining ☐ Resolved	Plan: Current Rx:
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Code if Present:	☐ Active/Stable ☐ Acute ☐ Declining ☐ Resolved	Plan: Current Rx:
Provider Signature	Credentials	Date

Provider Signature: ______________________________ Date: ______________