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NORTHSIDE HOSPITAL

Peachtree Dunwoody Medical Associates

Patient's name: _____ **Date of Birth:** _____

Medicare B enrollment date: _____ *

Today's date: _____

Health Risk Assessment has been reviewed by physicians, signed and dated: Initial_____

MEDICAL/SOCIAL HISTORY

Past personal illnesses or injuries:

Injury/Illness/Surgery	Date	Hospitalized? (Indicate Yes or No)

Medications, supplements and vitamins:

Drug allergies/other allergies:

Social history notes (including diet, physical activities, alcohol use, drug use and tobacco use):

Family history notes:

	Mother	Father	Brother	Sister	Son	Daughter
Deceased						
Hypertension						
Stroke						
Diabetes						
Kidney disease						
Heart disease						
Cancer						

Other physicians and providers/suppliers of care (include provide name, specialty & type of care)

WELCOME TO MEDICARE
IPPE/ANNUAL WELLNESS VISIT

DEPRESSION SCREEN*

1. Over the past 2 weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ No
2. Over the past 2 weeks, have you felt little interest/pleasure in doing things? ☐ Yes ☐ No

TO BE COMPLETED WITH THE PROVIDER

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____ BMI:_____

Visual Acuity:

	With Correction	Without correction
L		
R		
Both		

FUNCTIONAL ABILITY/SAFETY SCREEN*

1. Was the patient's timed Up & Go test unsteady or long than 30 seconds? ☐ Yes ☐ No
2. Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? ☐ Yes ☐ No
3. Does your 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

*A "yes" answer to any of the questions regarding depression or function/safety should trigger further evaluation, screenings or referrals.

(Use additional screening questionnaires)

EVALUATION OF COGNITIVE FUNCTION

Mood/Affect: _____

Appearance: _____

Family member/Caregiver input: _____

ELECTROCARDIOGRAM (G0403-EKG) – Only at the time of the IPPE

Referral or result: _____

EVALUATIONS/REFERRALS BASED ON HISTORY, EXAM AND SCREENING:

DISCUSSION OF ADVANCE DIRECTIVE (PATIENT PREFERENCE, PHYSICIAN AGREEMENT/DISAGREEMENT-if patient consents):

☐ **List of Community Resources was given to patient**

Physicians signature: _____ **Date:** _____