__IPPE

__INITIAL AWV MEDICARE PREVENTATIVE PHYSICAL EXAM

__Subsequent AWV

PATIENT NAME		**DATE OF BIRTH:**	

Depression Screen:	**Functional Ability/ Safety Screening:**
Over the past two weeks, have you felt down, depressed or hopeless? _____Yes _____ No Over the past two weeks have you felt little interest or pleasure in doing things? _____Yes _____ No	Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? ___ Yes ____No Does your residence have unsafe rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting? ____Yes ____No Do you have hearing difficulties? ____Yes ____No

List other doctors that you routinely see:

Cognitive Function Eval: (AWV)

Do you have any concerns about memory or other cognitive functions? ____Yes ____ No

If "yes" please circle the types of concerns you have below:

Remembering to take medications, remembering appointments, recalling recent events, remembering names, word retrieval, completing tasks, recalling historical events and dates, remembering holidays or family events.

Advance Care Planning: (IPPE)

Do you have an advance directive, living will or power of attorney: _____Yes _____No

The Patient was offered the opportunity to discuss advance care planning. __✓__Yes _____No

Vision Exam (IPPE)	Visual acuity: OS: _____ OD_____ OU _____

Items below were reviewed with the patient and updated in chart

__✓__ chronic and acute problem list	__✓__ family history
__✓__ surgical history	__✓__ social history (smoking alcohol, drugs)
__✓__ medications and allergies	__✓__ diet and physical activities

Was the timed Up and Go unsteady > 30 seconds? _____Yes __✓__No

Recommendations for Preventative Services:

Vaccines: _____Pneumovax _____ Influenza _____ Hepatitis B _____ Zostavax

Mammogram:		**Diabetes self management training:**		**Lipid Profile:**	
Pap and Pelvic:		**Medical Nutrition screening for diabetes or renal disease:**		**Diabetes screening test:**	
Prostate cancer Screen:		**Glaucoma Screening:**		**Abdominal aortic aneurysm screening:**	
Colorectal cancer screen:		**DEXA scan:**		**HIV screening:**	

Other:

MD Signature:_____ Date:_____ Copy given to patient