

MEDICARE INITIAL PREVENTIVE PHYSICAL EXAMINATION ENCOUNTER FORM

Name: _____ Age: _____ DOB: _____ Chart: _____ Date: _____ Allergies: _____

CC: Welcome to Medicare Physical

PMH: __No change since _____ See note/flow sheet

Diagnosis __See Flowsheet

Diagnosis

Other History

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: _____

Social History: Smoking: _____ ETOH: _____ Exercise: _____

Medications: __See scanned list:

TO BE FILLED OUT BY PROVIDER:

EXAM: Ht: _____ Wt: _____ T: _____ BP: _____ Pulse: _____ RR: _____ BMI: _____

Visual Acuity: L: _____ R: _____ Both: _____ or Date of last eye exam if within last 12 months: _____

√=Normal

General Awake/Alert No Distress	ENT EAC/TM's Nose OP	CV Rate/Rhythm Pulses Edema	GU-Male Penis Testes Prostate	Neurological Orientation Speech CNs 2-12 Strength Bulk/tone Sensation Coord. Gait DTR's
Skin Inspection Palpation	Neck Nodes Goiter	GI Bowel Sounds Liver Spleen Palpation Rectal/FOB	GU-Female Ext. Genitalia Vag. Canal Cervix Adnexa	
Eyes Pupils Conjunct Sclera Fundo Vision	Lungs Breathing sounds Clubbing Percussion	Breast Axilla Skin Palpation Nipples	Musculoskeletal Joints Muscle	Psychiatric Affect Judgment

Electrocardiogram/Labs: _____

Discussion of Advance Directive (Patient Preference, Physician Agreement/Disagreement):

Name: _____ DOB: _____ Date of Visit: _____

Service	Limitations	Recommendation	Scheduled
Vaccines •Pneumococcal •Influenza •Hepatitis B (if medium/high risk)	Medium/High Risk • ESRD • IVDA • Hemophilia • Institutionalized • Homosexual men		
Mammogram			
Pap and Pelvic exams			
Prostate cancer screen • Digital rectal exam (DRE) • PSA			
Colorectal cancer screen • Fecal occult blood test • Flexible sigmoidoscopy • Screening colonoscopy • Barium enema	Exempt from Part B deductible		
Bone mass measurements (DEXA)	Requires diagnosis related to osteoporosis or estrogen deficiency		
Diabetes self-management training	Requires referral		
Glaucoma screening			
Medical nutrition therapy for DM or renal DX	Requires referral		
Cardiovascular screening blood test • Total cholesterol • HDL • Triglycerides	Order as a panel if possible		
Diabetes screening tests • Fasting blood sugar (FBS) or glucose tolerance test (GTT)	DX of one • HTN • Dyslipidemia • Obesity (BMI ≥ 30) • Previous elevated FBS or GTT DX of at least 2 • Overweight (BMI ≥ 25 but < 30) • Family history diabetes • Age 65 or older • History of gestational DM or baby > 9 lbs		
Abdominal/Aortic Aneurysm Screening • Sonogram	Referred through IPPE and not had a screening for AAA before under Medicare. Needs one of the following: • Men who are 65-75 years old and have smoked more than 100 cigarettes in their lifetime • Anyone with a family history of AAA • Anyone recommended for screening by the U.S. Preventative Services Task Force		

Assessment/Plan:

Provider Signature: _____ RTC: _____

Patient Name: _____ DOB: _____ Date of Visit: _____

HEARING SCREENING:

	Yes	No
1. Do you have a problem hearing over the telephone?		
2. Do you have trouble following the conversation when two or more people are talking at the same time?		
3. Do people complain that you turn the TV volume up too high?		
4. Do you have to strain to understand conversation?		
5. Do you have trouble hearing in a noisy background?		
6. Do you find yourself asking people to repeat themselves?		
7. Do many people you talk to seem to mumble (or not speak clearly)?		
8. Do you misunderstand what others are saying and respond inappropriately?		
9. Do you have trouble understanding the speech of women and children?		
10. Do people get annoyed because you misunderstand what they say?		
TOTAL "Yes" responses (2 or more indicates the need for a referral)		

BALANCE/FALL SCREENING

	Yes	Sometimes	No
Do you feel depressed about your dizziness/imbalance?			
Does walking down a sidewalk increase your dizziness/imbalance?			
Is it difficult to concentrate due to dizziness?			
Is it difficult for you to walk around your house in the dark due to dizziness?			
Does bending over increase your dizziness/imbalance?			
Do you restrict travel for business/recreation due to your dizziness/imbalance?			
Does your dizziness/imbalance interfere with job/household responsibilities?			
Are you afraid to leave the house alone due to dizziness/imbalance problems?			
Have you ever been embarrassed around others due to dizziness/imbalance?			
Does your dizziness/imbalance cause significant social restrictions?			
Have you fallen in the past year?			
Totals: "Yes" = 4 pts., "Sometimes" = 2 pts., "No" = 0 pts., Abnormal =2-4 pts.			

DEPRESSION SCREEN

	Yes	No
Over the past two weeks, have you felt down, depressed or hopeless?		
Over the past two weeks have you felt little interest or pleasure in doing things?		

Have you had any of the following symptoms in the past four months?

- | | | |
|---|--|--|
| <input type="checkbox"/> Weight Loss/gain | <input type="checkbox"/> Cough | <input type="checkbox"/> Yellow eyes/skin |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Difficulty urinating/incontinent |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Backache | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Joint swelling or pain | <input type="checkbox"/> Excessive tiredness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest pain/pressure/heaviness | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Change in eyesight | <input type="checkbox"/> Stomach/abdominal pain | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Depression/tearfulness |
| <input type="checkbox"/> Ears ringing/hearing loss | <input type="checkbox"/> Nausea vomiting | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Swelling of the ankles | <input type="checkbox"/> Constipation | <input type="checkbox"/> Extra heart beats or racing heart |
| <input type="checkbox"/> Black or bloody bowel movements | <input type="checkbox"/> Heartburn/indigestion | <input type="checkbox"/> Unusual bruising or bleeding |
| <input type="checkbox"/> Changes in wart/mole/skin growth | <input type="checkbox"/> Difficulty swallowing/food sticking | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Nasal congestion/drainage | <input type="checkbox"/> Loss of strength or speech | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> face pain | <input type="checkbox"/> Leg cramps |

Provider Signature: _____ Date: _____