

Annual Health Assessment Form

Date of Service	Patient Name	DOB	Health Plan
Temp	BP	HR	Ht
Gender	Male	Female	Allergies
PCP	Marital 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	Date: ____ / ____ / 20 ____	Code: 1125F
	No	Date: ____ / ____ / 20 ____	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	Date: ____ / ____ / 20 ____	Code: 1157F
	Yes	Date: ____ / ____ / 20 ____	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: _____

Managed by

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 No Depression	5-9 Mild Depression	10-14 Moderate Depression	15-19 Moderate to Severe Depression	20-27 Severe Depression
				Total: _____ /27
PHQ9 Score < 10 _____ > _____				

Chief Complaints/History of Present Illness	Current Medications & Dosage																														
_____	_____																														
_____	_____																														
_____	_____																														
Family History																															
<table border="0"> <tr> <td></td> <td>Father</td> <td>Mother</td> <td>Children</td> <td>Siblings</td> <td>Grandparents</td> </tr> <tr> <td>Cancer</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Diabetes</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Heart Disease</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hypertension</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Father	Mother	Children	Siblings	Grandparents	Cancer						Diabetes						Heart Disease						Hypertension						_____
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Cancer																															
Diabetes																															
Heart Disease																															
Hypertension																															
Past Medical History																															

Social History																															
Drug Abuse/Dependence _____ Smoking: Past _____ Pap Smear _____ Nutrition Counseling _____	Education Provided Alcohol Abuse/Dependence _____ Current, # of packs _____ High Risk Lifestyle _____																														

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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Provider Signature

Credentials

Date

Provider Signature: _____ Date: _____