Patient Name:_____ **DOB:**_____ **Date:**_____

Annual Wellness Visit

Arizona Priority Care

Chief Complaint/HPI:

MEDICAL & SURGICAL HISTORY

Please ✓: (past conditions, injuries, operations, hospitalization)

☐ CAD	☐ CVA	☐ Heart Failure	☐ Cancer (specify) _____
☐ Old MI	☐ Late effect CVA	☐ Hypertension	☐ Amputations (location) _____
☐ PVD	☐ DVT	☐ Hypercholesterolemia	☐ Ostomy (location) _____ **Circle**: Active or Reversed)
☐ COPD	☐ PE	☐ Osteoporosis	
☐ CKD	☐ Seizure	☐ Pathologic Compression Fx	
☐ Renal Dialysis	☐ Chronic Hep B	☐ Major Depression	☐ Major Organ Transplant _____
☐ Diabetes	☐ Chronic Hep C	☐ Dementia	

OTHER

FAMILY MEDICINE

(i.e. Alcoholism, Bleeding Disorders, Cancer, CAD, Diabetes, Memory Loss, Mental Disorders)

Mother	
Father	
Siblings	
Other	

☐ NKA ALLERGY LIST with REACTION

Medication	Dosage	Diagnosis	Medication	Dosage	Diagnosis
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

☐ All Medication Reviewed With Patient (provider must ✓ box)

SPECIALISTS & DME SUPPLIERS

Fax Completed Form to Arizona Priority Care at: 480-403-8209

Revised 1/2/2018

Patient Name:_____ **DOB:**_____ **Date:**_____

SOCIAL HISTORY

Living Arrangements: ☐ Alone With: ☐ Spouse ☐ Family ☐ Caregiver ☐ Assisted Living

Occupation:	Retired ☐ Yes	Exercise type/frequency

Tobacco ☐ Current ☐ Smoke ☐ Chew Pack/Years: ☐2nd Hand ☐Never ☐Prior Use Quit Date:

Alcohol ☐ Never ☐ Occasional ☐ Daily #of drinks _____ day/ week/ month/ year

CAGE Questionnaire: ☐**1**.Have you ever felt you should **C**ut down ☐**2.**Have people **A**nnoyed you by criticizing you're drinking? ☐ **3.**Have you ever felt bad or **G**uilty about your drinking? ☐**4**. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye Opener)?

Score of ≥ 2 considered clinically significant. Please consider further evaluation using the Alcohol Use Disorder DSMV diagnostic criteria tool

ADVANCE DIRECTIVE (CPT II code: 1157F OR 1158F)

Advance Directive on file? ☐ Yes ☐ No	☐ If NO, discussed Advanced Directives with patient

FUNCTIONAL STATUS ASSESSMENT (CPTII CODE: 1170F)

1.	Have you had any falls in the past year? If "**yes**"; how many falls: _____	☐ Yes	☐ No
2.	Do you have any weaknesses of the extremities that interfere with your self-care or motility?	☐ Yes	☐ No

3. Have you noticed any difficulties with the following? (✓all that apply)

☐ Vision ☐ Hearing ☐ Speech

4. Do you need any assistance with the following? (✓all that apply)

☐ Dressing ☐ Bathing ☐ Toileting ☐ Transferring ☐ Eating/Feeding

5. Do you need assistance with any of the following? (✓all that apply)

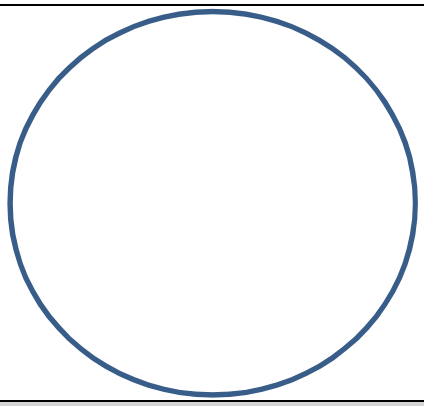
☐ Shopping ☐ Driving ☐ Using the telephone ☐ Meal preparation ☐ Housework ☐ Home repair
☐Laundry ☐ Taking medications ☐Handling finances

COGNITIVE SCREEN (Mini-Cog)

Ask patient to repeat & remember these three words **1. House 2. Pen 3. Apple**

After they draw the clock ask patient to recall the words	Circle how many words recalled? **1 2 3**

Ask the patient to put in the numbers and set the hands at 10 minutes after Eleven O'clock



Please ✓:

☐ 3 recalled words (Negative for cognitive impairment)
☐ 1 - 2 recalled words & normal Clock (Negative for cognitive impairment)
☐ 1 - 2 recalled words & abnormal Clock (Positive for cognitive impairment)
☐ 0 recalled words (Positive for cognitive impairment)

If positive then perform and score a Mini-Mental Exam

PAIN SCREENING (CPTII CODES: 0521F, 1125F OR 1126F)

Do you have any pain? ☐ Yes ☐ No	If so where?

If pain is present, circle intensity (0=no pain; 10=worst pain):

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

What causes or increases the pain?	Treatment plan

Fax Completed Form to Arizona Priority Care at: 480-403-8209

Patient Name:_____ **DOB:**_____ **Date:**_____

DEPRESSION SCREENING - PHQ-9 Intended for: screening patients w/o diagnosis of Major Depression or to monitor treatment of Major Depression				
Over the past 2 weeks, how often have you been bothered by any of the following problems?) (use "X" to indicate your answer)	None **0**	Several Days **1**	More Than ½ the Days **2**	Nearly Every Day **3**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts you would be better off dead, or of hurting yourself in some way				
(If you ✓ any problems) How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people	Not difficult	Somewhat difficult	Very difficult	Extremely difficult
If there are at least 5 ✓s in the shaded section of questions 1-9 (one must be question #1 or #2) and a response in the shaded area of the last question, then consider diagnosing Major Depression (see page 4) **TOTAL SCORE:**				
Interpreting PHQ-9 Scores: **5 – 9 (**Mild Depression**), 10 – 19 (**Moderate Depression**), 20 – 27 (**Severe Depression**)**				

COUNSELING AND REFERRAL OF PREVENTIVE SERVICES

★ **Mammogram:** Female Age 50 – 74 (every 2 years) Date: _____ Result: _____ Where:_____

★ **Colorectal Cancer screening** (Age 50 – 75): Date: _____ Result:_____ Where:_____

Please ✓ one: ☐ Colonoscopy (every 10 years) ☐ Fit DNA (every 3 years) ☐ gFOBT/FIT-FOBT (yearly)

★ **Bone Density Scan:** Female Age 67 – 85 (every 2 years) Date: _____ Result:_____ Where:_____

★ **Diabetic HbA1c: every 3-6 months** (goal < 9%) Date:_____ Result: _____

★ **Diabetic Nephropathy screening (Annually):**

- Urine Micro-Albumin/Urine protein Test Date: _____ Result: ☐ Positive ☐ Negative

★ **Diabetic Retinopathy Screen (Annually):** Date: _____ Result: ☐ Positive ☐ Negative

★ **Rheumatoid Arthritis present:** ☐ Yes ☐ No

- If ✓ Yes: **Patient on DMARD:** ☐ Yes ☐ No Drug Name: _____ Date Filled:_____
  Pharmacy:_____
- If ✓ No, **Reason**:_____

Please ✓ one or both, if present:

★ **Diabetes present** ☐ Yes ☐ No **OR** **Cardiovascular Disease OR Cardiac Event** ☐ Yes ☐ No

- If ✓ Yes: **Patient on Statin Meds:** ☐ Yes ☐ No Drug Name: _____ Date Filled:_____
  Pharmacy:_____
- If ✓ No, Reason: **Please ✓** ☐ Statin Induce Myalgia (M79.1) ☐ Myopathy, Unspec (G72.9) ☐ Rhabdomyolysis (M62.82)
  ☐ Statin Induced Myopathy (G72.2) ☐ Other:_____

Fax Completed Form to Arizona Priority Care at: 480-403-8209

Revised 1/2/2018

Patient Name:_____ **DOB:**_____ **Date:**_____

VITALS					
Ht:	**Wt:**	**BMI:**	**BP:**	**HR:**	**O2 SAT:**

REVIEW OF SYSTEMS

General: **HEENT:**

Resp: **CV:**

GI: **MS:**

GU: **Neuro:**

Vascular/Hematologic: **Endocrine:**

Reproductive: **Psych:**

PHYSICAL EXAM

General: (Check for significant weight loss: 5% in 3 months; 10% in 6 months; and if present, consider dx protein calorie malnutrition)
☐ WNL ☐ Malnutrition ☐ Cachexia

HEENT: ☐ WNL Findings: **Heart:** ☐ WNL Findings:

Lung: ☐ WNL Findings: **Abdomen:** ☐ WNL Findings:

Musculoskeletal: ☐ WNL ☐ Muscle Pain
Findings:

Genitourinary: ☐ WNL
Findings:

Extremities: ☐ WNL ☐ Ulcer ☐ Decrease sensation Other Findings:

Neuro: ☐ WNL ☐ Hemiparesis ☐ Monoplegia ☐ Paraparesis ☐ Quadriplegia
Other Findings:

Skin: ☐ WNL ☐ Senile Purpura Locations:_____ ☐ Other Findings:

Other:

ASSESSMENT AND PLAN

☐**NA** **MORBID OBESITY**

(Diagnose Morbid Obesity if BMI is over 40, or over 35 with a co-morbid condition)

Morbid Obesity: ☐ Yes BMI ≥ 40 ☐ Yes BMI 35-39.9 (✓ below)	☐ Stable ☐ Improving ☐ Worsening	**Plan:**

Co-Morbid Conditions: ☐ DM ☐ CAD/Heart disease ☐ MDD ☐ HTN ☐ Hyperlipidemia ☐ Obstructive Sleep Apnea ☐ Mod/Severe GERD ☐ Mod/Severe OA ☐ Stress Urinary Incontinence ☐ Cancer

☐**NA** **RESPIRATORY**

(✓ all that apply)

☐ COPD ☐ Emphysema ☐ Chronic Bronchitis ☐ Chronic Respiratory Failure (on Home O2) ☐ Lung Granuloma	☐ Stable ☐ Improving ☐Worsening	**Plan:**

Fax Completed Form to Arizona Priority Care at: 480-403-8209

Patient Name:_____ **DOB:**_____ **Date:**_____

☐NA **DIABETES MELLITUS** ☐ Type I ☐ Type II		
☐ DM with no Complication	☐ Stable ☐ Improving ☐ Worsening	**Plan:**
☐ Diabetic Hyperglycemia (HbA1c ≥ 7)	☐Stable ☐ Improving ☐Worsening	**Plan:**
☐ DM with Diabetic CKD ☐ CKD Stage _____	☐Stable ☐ Improving ☐Worsening	**Plan:**
☐ DM with Diabetic Polyneuropathy	☐Stable ☐ Improving ☐Worsening	**Plan:**
☐ DM with Proliferative Diabetic Retinopathy ☐ DM with Non-Proliferative Diabetic Retinopathy ☐ Diabetic Cataract	☐Stable ☐ Improving ☐Worsening	**Plan:**
☐ DM With Diabetic Peripheral Angiopathy ☐ Diabetic Atherosclerosis of Aorta ☐ Diabetic Atherosclerosis of Extremities	☐Stable ☐ Improving ☐Worsening	**Plan:**
☐ DM with Other Manifestations (Please ✓ below for linkage) ☐ Diabetic ulcer ☐ Diabetic CAD ☐ Diabetic HTN ☐ Diabetic Dyslipidemia ☐ Diabetic ED	☐Stable ☐ Improving ☐Worsening	**Plan:**

☐NA **POLYNEUROPATHY** (cause or associated condition can be found in 60% of unspecified Neuropathy cases)	
Polyneuropathy Due To: ☐ B Vitamin Def ☐ Drugs_____ ☐ HIV ☐ Alcohol ☐ Amyloidosis ☐ Collagen Vascular Disease ☐ Nutritional Def ☐ Hyperglycemia/PreDM ☐ Metabolic disorder ☐ CKD (uremia) ☐ Radiation ☐ Cancer	
Please ✓ ☐ Stable ☐ Improving ☐ Worsening	**Plan:**

☐NA **MAJOR DEPRESSION** (If patient is on an antidepressant to treat a mood disorder)	
Major Depression: ☐ Single Episode ☐ Recurrent	**Please ✓One**: ☐ Mild ☐ Moderate ☐ Severe ☐ With Psychotic Features ☐ Partial Remission ☐ Full Remission
Please ✓ ☐ Stable ☐ Improving ☐ Worsening	**Plan:**

☐NA **CARDIAC/VASCULAR** (✓ all that apply)		
Angina: Please ✓ ☐ CAD without Angina ☐ CAD S/P CABG with Angina ☐ CAD S/P Stents with Angina	☐ Stable ☐ Improving ☐ Worsening	**Plan: Continue (please ✓ at least one)** ☐ Beta Blocker ☐ Calcium Channel Blocker ☐ Nitrates
Arrhythmias: Please ✓ ☐ AFIB ☐ A-Flutter ☐ SVT ☐ VT ☐ SSS ☐ Complete Heart Block	☐ Stable ☐ Improving ☐ Worsening	
Aortic Disease: Please ✓ ☐ Aortic Atherosclerosis ☐ AAA ☐ Aortic ectasia ☐ Aortic Tortuosity	☐ Stable ☐ Improving ☐ Worsening	
Vascular Disease: Please ✓ ☐ PVD ☐ Claudication ☐ Atherosclerosis of Ext ☐ Atherosclerosis of Ext with Ulcer ☐ Chronic DVT ☐ Chronic PE	☐ Stable ☐ Improving ☐ Worsening	
Heart Failure: Please ✓ ☐ CHF ☐ Cardiomyopathy ☐ Chronic Systolic Heart Failure ☐ Chronic Diastolic Heart Failure	☐ Stable ☐ Improving ☐ Worsening	

Fax Completed Form to Arizona Priority Care at: 480-403-8209

Patient Name:_____ **DOB:**_____ **Date:**_____

☐NA	**DRUG DEPENDENCE**

Dependence to: ☐Opioids ☐Benzodiazepine ☐Cannabis ☐Cocaine ☐ Amphetamine ☐ Alcohol
(**MUST** indicate at least 4 or more criteria to diagnose dependence: unless in remission)

☐ Withdrawal symptoms ☐ Intake is larger or a longer period of time than intended ☐Unsuccessful efforts to quit ☐Excessive time spent obtaining and using or recover from aftereffects ☐ Tolerance ☐ Craving ☐ Given up or reduced activities that were once enjoyable in order to drink/use ☐ Continuous use despite failure to fulfill major role obligation at work, school, home ☐Continued use despite causing trouble with family and friends ☐Recurrent use in situations in which it is physically hazardous ☐Continued use despite knowledge of it causing or worsening a persistent or recurrent physical or psychological problem

Please ✓ ☐ Continuous ☐ Episodic ☐ In Remission

Please ✓ ☐Stable ☐ Improving ☐Worsening	**Plan:**

OTHER CHRONIC CONDITIONS

(List all ACTIVE chronic conditions. If a CANCER has been fully treated then diagnose it as "History Of")

Diagnosis	Status (Please ✓)	Plan
	☐ Stable ☐ Improving ☐ Worsening	
	☐ Stable ☐ Improving ☐ Worsening	
	☐ Stable ☐ Improving ☐ Worsening	
	☐ Stable ☐ Improving ☐ Worsening	
	☐ Stable ☐ Improving ☐ Worsening	
	☐ Stable ☐ Improving ☐ Worsening	
	☐ Stable ☐ Improving ☐ Worsening	
	☐ Stable ☐ Improving ☐ Worsening	
	☐ Stable ☐ Improving ☐ Worsening	
	☐ Stable ☐ Improving ☐ Worsening	
	☐ Stable ☐ Improving ☐ Worsening	
	☐ Stable ☐ Improving ☐ Worsening	
	☐ Stable ☐ Improving ☐ Worsening	
	☐ Stable ☐ Improving ☐ Worsening	

I certify that the information provided on this assessment form is accurate, complete and current as of the date of exam noted on this page. I have personally examined the patient and indicated the patient's condition by noting the relevant diagnoses and supporting information. The diagnoses have been derived through patient history, face-to-face patient examination, and completion of diagnostic studies. I understand this document will become a permanent part of the patient's medical records at both my office & *AZPC*.

Provider Signature:_____ **M.D. D.O. N.P. P.A.** (Circle one)

Print Provider Name: _____ **Date:** _____

Fax Completed Form to Arizona Priority Care at: 480-403-8209