



Annual Wellness Assessment

Patient Full Name: _____ DOB: ____/____/____ Gender: Male / Female / Other

Member ID#: _____ Health Plan: _____ Allergy: _____ Date: ____/____/____

Date of Birth Date of Service

Patient Identifier

Vital Signs BP: ____/____ HR: _____ Ht: _____ ft. _____ in. _____ Wt (lbs.) _____ BMI: _____

IHA/AHA CPT Codes: G0402 Initial physical, New patient G0438 Annual wellness visit, First visit G0439 Annual wellness visit, Subsequent visit

Procedure Code 3008F **Check the Appropriate "BMI" Code below:**

BMI < 19 (Z68.10); BMI 20.0-20.9 (Z68.20); BMI 21.0-21.9 (Z68.21); BMI 22.0-22.9 (Z68.22); Wheelchair Dependent (Z99.3)

BMI 23.0-23.9 (Z68.23); BMI 24.0-24.9 (Z68.24); BMI 25.0-25.9 (Z68.25); BMI 26.0-26.9 (Z68.26); BMI 27.0-27.9 (Z68.27);

BMI 28.0-28.9 (Z68.28); BMI 29.0-29.9 (Z68.29); BMI 30.0-30.9 (Z68.30); BMI 31.0-31.9 (Z68.31); BMI 32.0-32.9 (Z68.32)

BMI 33.0-33.9 (Z68.33); BMI 34.0-34.9 (Z68.34); BMI 35.0-35.9 (Z68.35); BMI 36.0-36.9 (Z68.36); BMI 37.0-37.9 (Z68.37); BMI 38.0-38.9 (Z68.38)

BMI 39.0-39.9 (Z68.39); BMI 40.0-40.9 (Z68.41); BMI 45.0-45.9 (Z68.42); BMI 50.0-50.9 (Z68.43); BMI 60.0-69.0 (Z68.44); BMI 70 or greater (Z68.45)

Check the Appropriate "Blood Pressure" Procedures (SBP =Systolic BP; DBP =Diastolic BP):

SBP < 130 (3074F); SBP 130-139 (3075F); SBP 140 or over (3077F); DBP < 80 (3078F); DBP 80-89 (3079F); DBP 90 or over (3080F)

History of Present Illness: _____ (reason for visit)

Review of systems

Past Medical, Family and Social History

Physical Exam (Please complete thoroughly each section unless exam component was deferred)

If deferred, check here <input type="checkbox"/>	Normal	Abnormal	Describe Finding
<input type="checkbox"/>	GENERAL		
<input type="checkbox"/>	HEAD		
<input type="checkbox"/>	EYES		
<input type="checkbox"/>	ENT		
<input type="checkbox"/>	NECK		
<input type="checkbox"/>	RESP		
<input type="checkbox"/>	CV		
<input type="checkbox"/>	CHEST / BREAST		
<input type="checkbox"/>	GI		
<input type="checkbox"/>	LYMPH		
<input type="checkbox"/>	MS		
<input type="checkbox"/>	SKIN		
<input type="checkbox"/>	PSYCH		
<input type="checkbox"/>	NEURO	Alert/Oriented to: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time <input type="checkbox"/> Situation	

OTHER LAB RESULTS (state specific findings & add diagnosis to assessment/plan)

OTHER XRAY RESULTS (state specific findings & add diagnosis to assessment/plan)

SCREENING	RESULTS	DATE OF SCREENING	NEXT SCREENING	CPT 2 CODES
Breast Cancer Screening (every 2 yrs., ages 50-74)	Mammogram: Findings:			77055 unilateral, 77056 bilateral, 77057 bilateral (2 views of each breast) G0202 bilateral (2view study of each breast including CAD; G0204 bilateral study including CAD; G0206 unilateral study including CAD 77063 Screening digital tomosynthesis (bilateral) G0279 Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to G0204 or G0206)
Cervical Cancer Screening (every 3 yrs., ages 21-64)	Lab Result: Findings:			Cervical Cytology: 88141-88143 HPV Test: 87620-87622
Colon Cancer Screening FOBT or FIT test annually, Sigmoidoscopy every 5yrs, Colonoscopy x10 yrs; ages 50-75	Colonoscopy Results:			FOBT: 82270, 82274 FIT: 82274 Flexible Sigmoidoscopy: 45330-45335 Colonoscopy: 45378
Diabetes Nephropathy Urine Microalbumin Screening (annually)	Results: Positive <input type="checkbox"/> Negative <input type="checkbox"/>			(+) 3060F (-) 3061F
Diabetes: A1c screening (annually)	Lab Results (e.g. 7.3%): _____			(<7%): 3044F, (7-9%): 3045F, (>9.0%): 3046F
Lipid Panel Test (annually) LDL-C<100MH/DL LDL-C 100-129MG/DL LCL-C<130MG/DL	Lab Result:			3011F 3048F 3049F 3050F



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Date of Birth Date of Service

Depression Screening (PHQ9) Code: G0444

Over the last 14 days, how often have you been bothered by any of the following problems?	<input type="checkbox"/> 0	<input type="checkbox"/> 1 to 6	<input type="checkbox"/> 7 to 11	<input type="checkbox"/> 12+
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, Depressed or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Trouble falling asleep, staying asleep, or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Trouble concentrating on such things as reading the newspaper or watching TV	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling bad about yourself, feeling that you are a failure, feeling that you have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Thinking that you would be better off dead or that you want to hurt yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Diagnosis Guide	Total score: Depression Severity: 1-4 Minimal Depression 5-9 Mild Depression 10-14 Moderate depression 15-19 Moderately severe depression - Refer to Case Management 20-27 Severe depression - Refer to Case Management	Total score:

Unable to complete the depression assessment due to: Unresponsive Uncooperative Severe Dementia Patient Refused Other (explain below)

On Treatment for Depression? Yes No

Additional Notes / Comments:

Physicians to complete:

DIAGNOSIS DESCRIPTION	STATUS OF DIAGNOSIS	PLAN OF CARE / CURRENT RX
	<input type="checkbox"/> Stable <input type="checkbox"/> Condition worsening <input type="checkbox"/> Condition improving	
	<input type="checkbox"/> Stable <input type="checkbox"/> Condition worsening <input type="checkbox"/> Condition improving	
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	<input type="checkbox"/> Stable <input type="checkbox"/> Condition worsening <input type="checkbox"/> Condition improving	
	<input type="checkbox"/> Stable <input type="checkbox"/> Condition worsening <input type="checkbox"/> Condition improving	

I have reviewed this visit with the member and I hereby verify all of the above is correct.

Provider's Name (Print): _____ Provider's Signature: _____

Date: _____ Provider Credential (e.g., MD, DO, NP, PA): _____