COMMUNITY MEDICAL PROVIDERS
Medical Group

❑ G0402 IPPE (Welcome)
❑ G0438 – AWV (Annual)
❑ G0439 - Subsequent

Version: 04/2025

ANNUAL WELLNESS VISIT

Office staff: Medical Record Number: _____ Date of Service_____

PLEASE PRINT:

Patient Name _____

Date of Birth _____ Gender ☐Male ☐Female

Medicare B Eligibility Date _____

PAIN *[Office: EPIC's vital signs – pain information]*

⇨ Please Circle one:

How often is pain a problem for you?	Never	Sometimes	Often	Always

Where is your Pain? _____

Circle one of the faces below that best relates to your pain:

ALLERGIES – Please list all allergies or reactions to medications

⇨☐ Select this box if nothing has changed in the last year

Allergy/Medication:	Reaction:
☐ No Allergies	

MEDICATIONS – Please list all medications you are currently taking including prescriptions, supplements, cold medication, aspirin, and vitamins. Please list all medication dosages and frequency taken.

⇨☐ Select this box if nothing has changed in your Medications in the last year

Medication	Dosage	Frequency
☐ I take NO Medications		

MEDICAL HISTORY – Please list all illnesses and injuries and when they started. (For example: asthma, diabetes, high blood pressure, heart murmur, epilepsy, cancer, depression, accidents, fractures, head injuries, burns) *[Office Staff: EPIC's Medical History section & update Problem List]*

⇨☐ Select this box if No Changes in Medical History in the last year

Problem:	Date:

HOSPITALIZATIONS- Other than surgeries *[Office: EPIC's Medical/Surgical History section]*

Surgery for:	Date:
☐ Never have been hospitalized	
☐ No Hospitalizations in the last Year	

SURGICAL HISTORY- List all surgeries and the date of the surgery. (For example: tonsillectomy, appendix, gallbladder, hernia, hysterectomy) *[Office: EPIC's Surgical History section]*

Surgery for:	Date:
☐ No Surgeries	
☐ No New Surgeries in the last year	

FAMILY HISTORY – For blood relatives *[Office: EPIC's Family History section]*

⇨☐ Select this box if No Changes in Family History in the last year

	Age Now:	Or Age at Death:	Cause:
Mother			
Father			

Have any immediate family members (parents, brother, sister, grandparents, or children) had:

Yes	No	History of:	Which Family Member(s) / Age:
		Alcoholism	
		Asthma	
		Cancer	
		Depression	
		Diabetes	
		Drug Problem	
		Heart Attack	
		High Blood Pressure	
		High Cholesterol	
		Stroke	
Other illness or conditions that run in your family: _____			

SOCIAL HISTORY- *[Office: EPIC's History section]*

Have you smoked tobacco? ☐ Yes ☐ No *[Office: If Yes to smoking, give Smoking Cessation Counseling]*

(If you answered Yes)

How Often: *(Please Circle)*
Former Smoker
Everyday
Some Days

Type: *(Please Circle)*
Cigarettes
Pipe
Cigars

E-Cigarettes/Vaping? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If Yes, do you drink more than 4 drinks in a day or 28 in a week? ☐ Yes ☐ No

[Office: If Yes to more than 4 alcoholic drinks per day, perform AUDIT sheet]

How many alcoholic drinks per week? _____

Do you use recreational/illegal drugs? ☐ Yes ☐ No

If yes, what kind? _____

[Office: If Yes to illegal drug use, perform DAST Flowsheet)

Sexually Active? ☐ Yes ☐ Not Currently ☐ No

Occupation? ☐ Retired ☐ Employed, Employer: _____

Marital Status? ☐ Single ☐ Married ☐ Widowed ☐ Separated

What is your highest level of education? _____

Race *(ex: Caucasian, Chinese)*_____ Ethnicity *(ex: Hispanic, Non-Hispanic)*_____

Hobbies? _____

GYNECOLOGICAL HISTORY Women Only:

⇨☐ Select this box if No Changes in Gynecological History in the last year

Number of Pregnancies: _____

Number of Miscarriages: _____

Number of Children: _____

Number of Abortions: _____

ACTIVITIES OF DAILY LIVING *[Office: EPIC's Other Factors section]*

⇨☐ Select this box if No Changes in Activities of Daily Living in the last year

Back Care? ☐ Yes ☐ No	Gun Owner? ☐ Yes ☐ No	Sleep Concern? ☐ Yes ☐ No
Bike Helmet? ☐ Yes ☐ No	Hobby Hazards? ☐ Yes ☐ No	Smoke Detectors? ☐ Yes ☐ No
Blood Transfusion? ☐ Yes ☐ No	Military Service? ☐ Yes ☐ No	Special Diet? ☐ Yes ☐ No
Body Piercings? ☐ Yes ☐ No	Occupational Exposure ☐ Yes ☐ No	Stress Concern? ☐ Yes ☐ No
Caffeine Concern? ☐ Yes ☐ No	Seat Belt? ☐ Yes ☐ No	Tattoos? ☐ Yes ☐ No
Exercise? ☐ Yes ☐ No	Self-Exams? ☐ Yes ☐ No	Weight Concern? ☐ Yes ☐ No

SOCIAL DRIVERS OF HEALTH [Office: SDOH: financial, housing, transportation, food, utilities]

On average, how many days per week do you engage in moderate to strenuous exercise? _____

On average, how many minutes do you engage in exercise at this level? _____

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
☐ Very Hard ☐ Hard ☐ Somewhat Hard ☐ Not Very Hard ☐ Not Hard at All

In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
☐ Yes ☐ No

In the past 12 months, how many times have you moved where you were living? _____

At any time in the last 12 months, were you homeless or living in a shelter (including now)?
☐ Yes ☐ No

In the last 12 months, has lack of transportation kept you from medical appointments or from getting medications? ☐ Yes ☐ No

Kept you from meetings, work, or from getting things needed for daily living?
☐ Yes ☐ No

Within the past 12 months, you worried that food would run out before you got money to buy more.
☐ Never True ☐ Sometimes True ☐ Often True

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
☐ Never True ☐ Sometimes True ☐ Often True

Do you feel stress: tense, restless, nervous, or anxious, unable to sleep at night because your mind is troubled?
☐ Not at all ☐ Only a little ☐ To some extent ☐ Rather Much ☐ Very much

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?
☐ Never ☐ 1x week ☐ 2x week ☐ 3x week ☐ More than 3x week

How often do you get together with friends or relatives?
☐ Never ☐ 1x week ☐ 2x week ☐ 3x week ☐ More than 3x week

How often do you attend church or religious services?
☐ Never ☐ 1-4 times / year ☐ More than 4 times / year

Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups? ☐ Yes ☐ No

How often do you attend meetings of the clubs or organizations you belong to?
☐ Never ☐ 1-4 times / year ☐ More than 4 times / year

Are you married, widowed, separated, never married, or living with a partner?
☐ Married ☐ Widowed ☐ Separated ☐ Never married ☐ Living with a partner

Within the last year, have you been afraid of your partner or ex-partner?
☐ Yes ☐ No ☐ Decline to answer

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? ☐ Yes ☐ No ☐ Decline to answer

Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? ☐ Yes ☐ No ☐ Decline to answer

Within the last year, have you been raped or forced to have any sexual activity by your partner or ex-partner?
☐ Yes ☐ No ☐ Decline to answer

How often do you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ 2-4x month ☐ 2-3x week ☐ More than 4x week

How many drinks containing alcohol do you have on a typical day when drinking? _____

How often do you have six or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily

In the past 12 months has the electricity, gas, oil, or water company threatened to shut off services in your home? ☐ Never True ☐ Sometimes True ☐ Often True

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☐ Never ☐ Rarely ☐ Sometimes ☐ Always

➢ *Office Staff: Complete EPIC's vision/hearing (simple screen), timed up and go*

PHQ-9 SCREEN *[Office: EPIC's depression screening flowsheet]*

Over the past 2 weeks, how often have you been bothered by any of the following problems?				
	Not at all	**Several Days**	**More than half the days**	**Nearly everyday**
Little interest or pleasure in doing things ?	0	1	2	3
Feeling down, depressed, or hopeless?	0	1	2	3
Trouble falling or staying awake, or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	0	1	2	3
Trouble concentrating on things, sch as reading the newspaper or watching television?	0	1	2	3

	Not at all	Several Days	More than half the days	Nearly everyday
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	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way?	0	1	2	3
If you checked off any problems on this questionnaire,				
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 at all	Somewhat difficult	Very difficult	Extremely difficult

GAD-7 SCREEN *[Office: EPIC's GAD-7 Anxiety Scale flowsheet]*

Over the past 2 weeks, how often have you been bothered by any of the following problems?				
	Not at all	**Several Days**	**More than half the days**	**Nearly everyday**
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is had to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen?	0	1	2	3
If you checked off any problems on this questionnaire,				
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 at all	Somewhat difficult	Very difficult	Extremely difficult

- ***Office Staff: Complete 6CIT Flowsheet***

ACTIVITIES OF DAILY LIVING *[Office: EPIC AWV Health Risk Assessment Flowsheet]*
[Provider: if needed, consider Referral]

Yes	No	Do you have a well-balanced diet? If no, why? _____
How often do you exercise? ***Please Circle:*** Daily Weekly Never		
Yes	No	Do you drive?
Yes	No	Are you able to get on and off the toilet easy?
Yes	No	Do you have self-control over your bladder or bowel?
Yes	No	Do you need help with eating or meal preparation?
Yes	No	Do you need help shopping or doing light housekeeping?
Yes	No	Do you have difficulty doing errands alone?

Yes	No	Do you need help with dressing or bathing?
Yes	No	Do you have problem functioning sexually?
Yes	No	Do you have any trouble hearing?
Yes	No	Do you have any trouble seeing, even with glasses?
How many hours can you be left alone? _____		

COGNITIVE / FUNCTIONAL STATUS *[Office: EPIC AWV Health Risk Assessment Flowsheet]*

Yes	No	Are you having trouble concentrating or making your own decision?
Yes	No	You have trouble managing the mail or paying bills?
Yes	No	Are you having trouble ordering your medications or scheduling appointments?
Yes	No	Are you having trouble remembering to take your medications?
Yes	No	Do you have a decreased sense of direction?
Yes	No	During the past year have you experienced confusion or memory loss that is happening more often or getting worse?

GENERAL LIFE SATISFACTION *[Office: EPIC AWV Health Risk Assessment Flowsheet]*

[Provider: if needed, consider a Referral or further testing]

1. How Often do you get the social and emotional support you need?
   ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never
2. During the past four weeks, has your physical and emotional health limited your social activities with your family?
   ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never
3. During the past four weeks, was someone available to help you if you needed or wanted it?
   ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never
4. In general, how satisfied are you with your life?
   ☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied
5. How often is stress a problem for you?
   ☐ Never ☐ Sometimes ☐ Often ☐ Always

SAFETY SCREEN *[Office: If Yes for the fall questions (1&2), complete STEADI Fall Risk] [Office: EPIC AWV Health Risk Assessment Flowsheet]*

How many times have you fallen in the last year? _____		
Yes	No	Do you worry about falling?
Yes	No	Has anyone made you afraid or hurt you physically?
Yes	No	Have you been upset because someone talked to you in a way that made you feel ashamed or threatened?
Yes	No	Has anyone tried to force you to sign papers or to use your money against your will?

ADULT ACTIVITY LEVEL *[Office: EPIC Current Adult Activity Flowsheet]*

Please circle the number which best describes your level of activity:

For activity to be regular, it must add up to a total of 30+ mins/day and be done at least 5 days/week.

1	I currently do NOT exercise and do not intend to start exercising in the next 6 months.
2	I currently do NOT exercise but am thinking about starting in the next 6 months.
3	I currently exercise some, but not regularly.
4	I currently exercise regularly, but I have only begun to do so in the last 6 months.
5	I currently exercise regularly and have done so for longer than 6 months.

Please Circle:

Yes	No	Are you currently taking opioid (pain) medication?
Yes	No	Have you ever been hospitalized and/or treated for opioid overuse?

[Staff: if patient answered Yes, complete the Opioid Risk Tool and PEG]

HEALTH MAINTENANCE: *(Office: update EPIC's Care Gaps section)*

Immunizations:	Date Last Done:
Last tetanus shot:	_____
Pneumonia vaccine #1:	_____
Pneumonia vaccine #2:	_____
Last Flu shot:	_____
Hepatitis B Series:	_____
Covid Vaccine:	_____
RSV:	_____
Zostavax:	_____
Shingrix:	_____

Preventive Screenings:	Date Last Done:
DEXA:	_____
Colonoscopy:	_____
Eye Exam:	_____
FOBT (Fecal Occult Blood Test):	_____
Hep C (if born 1945-1965)	_____
Mammography:	_____
Lung Nodule Screening:	_____
Cardiovascular Disease:	_____
HIV Screening:	_____
Abdominal Aortic Aneurysm:	_____
Pap Smear (Female Only):	_____
PSA (Male Only):	_____

Please Circle: *[Staff: If patient answered Yes, do we have a scanned copy in the Directives section in EPIC?]*

Yes	No	Do you have a POLST or Advanced Care Directive?

Do you receive health care from other physicians or sources?

(Office: add physicians to EPIC's care team, patient care team section, team member on the Story Board)

⇨☐ Select this box if No Changes to your Care Team in the last year

YES	NO	Specialty	Provider Name	Reason for Visit?	Last Visit Date?
☐	☐	Audiologist (Hearing)			
☐	☐	Cardiologist (Heart)			
☐	☐	Dermatologist			
☐	☐	Dentist			
☐	☐	Gastrointestinal (GI)			
☐	☐	Optometrist (Eye)			
☐	☐	Podiatrist (Feet)			
☐	☐	Medical Equipment			
☐	☐	Home Health			
Other:					

HEALTH INFORMATION:

Who would be able to help you in case of illness or emergency?

Name: _____

Relationship: _____

Phone # _____

- Please sign here if you authorize us to discuss and send your healthcare information to the person listed above:_____ *(your signature)*

This form was filled out by (please print your name):

Name: _____

Relationship? _____

Staff Signature _____

Staff member conducting initial intake: _____ Date:_____

(*Office: HCC evaluation of conditions in the Problem's List and provide a DSP for each.)*

Provider Signature _____

Review/notation of

pertinent history performed: _____Date:_____