

## MEDICARE INITIAL PREVENTIVE PHYSICAL EXAMINATION ENCOUNTER FORM

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Medical record #: \_\_\_\_\_

Medicare B eligibility date: \_\_\_\_\_ Date of exam: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

### MEDICAL/SOCIAL HISTORY

Past personal illnesses or injuries:

Injury or illness	Date	Hospitalized?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug allergies: \_\_\_\_\_

Tobacco use: \_\_\_\_\_

Alcohol use: \_\_\_\_\_

Medications, supplements and vitamins:

Drug use: \_\_\_\_\_

Social history notes (including diet and physical activities):

Family history notes:

### DEPRESSION SCREEN

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

### FUNCTIONAL ABILITY/SAFETY SCREEN

1. Was the patient's timed Up & Go test unsteady or longer than 30 seconds? ☐ Yes ☐ No
2. Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? ☐ Yes ☐ No
3. Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting? ☐ Yes ☐ No
4. Have you noticed any hearing difficulties? ☐ Yes ☐ No

Hearing evaluation: \_\_\_\_\_

A "yes" response to any of the questions regarding depression or function/safety should trigger further evaluation.

### PHYSICAL EXAMINATION

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood pressure: \_\_\_\_\_ BMI: \_\_\_\_\_

Visual acuity: L \_\_\_\_\_ R \_\_\_\_\_

### ELECTROCARDIOGRAM

Referral or result: \_\_\_\_\_

EVALUATIONS/REFERRALS BASED ON HISTORY, EXAM AND SCREENING: \_\_\_\_\_

DISCUSSION OF ADVANCE DIRECTIVE (PATIENT PREFERENCE, PHYSICIAN AGREEMENT/DISAGREEMENT): \_\_\_\_\_