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:

<table>
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<tr>
<th>Injury or illness</th>
<th>Date</th>
<th>Hospitalized?</th>
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Drug allergies: __________________________
Tobacco use: ____________________________
Alcohol use: ____________________________
Drug use: _______________________________

Medications, supplements and vitamins:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

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):

_________________________________________________________________________
_________________________________________________________________________