

MEDICARE PREVENTIVE PHYSICAL EXAM

Today's Date ____ / ____ / ____

<input type="checkbox"/> Initial Preventive Physical Exam (Welcome to Medicare Physical)		<input type="checkbox"/> Initial annual wellness visit		<input type="checkbox"/> Subsequent annual wellness visit		<input type="checkbox"/> Other	
Patient name			Medical record #			Date of birth	
Staff conducting initial intake			Date of last exam			Medicare B eligibility date	
Language or other communication barriers: (describe)						Sex	LMP
Interpreter or other accommodation provided today: (describe)						Gravida/para	Year of menopause
Vital signs	Ht	Wt	BMI	Waist	BP	Temp	P/R
<input type="checkbox"/> Patient-completed health risk assessment (AWV only; e.g. www.medicalhealthassess.org)							

Social history							
Tobacco	<input type="checkbox"/> Current	Type:	Freq:	<input type="checkbox"/> 2nd hand	<input type="checkbox"/> Never	<input type="checkbox"/> Prior use	Quit date:
ETOH	<input type="checkbox"/> Never	<input type="checkbox"/> Occasional	<input type="checkbox"/> Daily	History of ETOH: (describe)			
Diet notes						Caffeine	<input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Daily
Drug abuse	<input type="checkbox"/> Never	<input type="checkbox"/> Occasional	<input type="checkbox"/> Daily	<input type="checkbox"/> Prior use	Quit date:		
History of drug abuse: (describe)							
Occupation					Exercise type/frequency		
Home environment	<input type="checkbox"/> Private home	<input type="checkbox"/> Assisted living	<input type="checkbox"/> Other: (describe)				

Family history use ✓ to indicate positive history									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart disease									
Stroke									
Kidney disease									
Obesity									
Genetic disorder									
Alcoholism									

continued ►



FPM Toolbox To find more practice resources, visit <https://www.aafp.org/fpm/toolbox>.

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Family history <small>continued</small> use ✓ to indicate positive history									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Liver disease									
Depression or manic depressive disorder									
Colon or rectal cancer									
Breast cancer									
Other cancer									
Other:									

Medical history				
Hospital visits since last office visit/reason	Facility	Attending physician	Date of hospital visit	Past surgeries (include date and description of any complications)

Injuries (since last physical exam)		
Date	Type	Treatment received

Allergy list	
Allergies	Type of reaction

Medication list if noted elsewhere in chart, indicate location:					
Herbals, supplements, OTC drugs, substances of abuse	Date started	Date discontinued	Rx meds, dose, frequency, route	Date started	Date discontinued

continued ►

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Medication list continued if noted elsewhere in chart, indicate location:					

Problem list				
Chronic problems	Date added	Managing physician (if other)	Date updated	Initial
Acute problems (R=resolved)	Date added	Managing physician (if other)	Date updated	Initial

Other physicians and providers of care (this documentation not required for IPPE)		
Name & specialty/provider type	Type of care	Date discontinued

➔ Physician/other provider sign here to indicate review/notation of pertinent history: _____

continued ►

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Depression screening		
1. Over the past two weeks, has the patient felt down, depressed or hopeless?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Over the past two weeks, has the patient felt little interest or pleasure in doing things?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Functional ability/Safety screening		
1. Was the patient's timed Up & Go test unsteady or longer than 30 seconds?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Does the patient need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Does the patient's home have rugs in the hallway, lack grab bars in the bathroom, lack hand-rails on the stairs or have poor lighting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you noticed any hearing difficulties?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing evaluation:		
A "yes" response to any of the above questions regarding depression or function/safety should trigger further evaluation.		

Evaluation of cognitive function (this documentation not required for IPPE)
Mood/affect
Appearance
Family member/caregiver input

Vision Examination
Visual acuity: L _____ R _____

Electrocardiogram referral or result (if performed/ordered [covered benefit for IPPE])

Advice/Referrals (based on history, exam and screening [including risks, interventions underway or planned, and benefits])

continued ►

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Chronic Care Management

Patient eligible Yes No If eligible, patient agreement form completed and documented? Yes No
If agreement, care coordinator notified? Yes No

Potential recommendations not covered as Medicare Part B preventive services (this documentation not required for IPPE)

Patients should contact their Part-D plan for information on preventive vaccines benefits.

Varicella vaccine	Aspirin therapy
Zoster vaccine (once)	Calcium supplement
Tdap vaccine (10 years)	Social services
Td vaccine (10 years)	Dietary counseling
MMR vaccine	
Meningococcal vaccine	
Hep A vaccine	

Handouts reviewed and discussed with patient

Discussion of advance directive (patient preference, physician agreement/disagreement):

continued ►

Patient Name _____ Today's Date ____ / ____ / ____

Create two copies of this page: One for your charts and one to give to your patient.	
Counseling and referral of other preventive services - Create two copies of this page: one for your charts and one to give to your patient. Note: Please see current Medicare Claims Processing Manual for coverage and eligibility details.	
Preventive Service	Recommendation/Scheduled/Next Due
Abdominal aortic aneurysm screening (covered only if ordered at time of IPPE)	
Alcohol misuse screening and counseling	
Annual Wellness Visit (AWV) - includes health risk assessment and a personalized prevention plan of service (PPPS); first visit 11 full months after IPPE and subsequent visit 11 full months after first or most recent AWV	
Bone mass measurements	
Breast cancer screening - mammogram	
Cardiovascular disease screening laboratory tests - Lipid panel	
Cardiovascular disease - intensive behavioral therapy	
Cervical and vaginal cancer screening - Pelvic and breast exam including Pap smear	
Colorectal Cancer Screening - Fecal occult blood test; flexible sigmoidoscopy; colonoscopy; stool-based DNA and fecal occult hemoglobin	
Colorectal cancer screening - Barium enema - patient cost co-pay applies, deductible waived	
Depression screening	
Diabetes screening - glucose testing	
Diabetes self-management training - patient cost 20% after deductible (program accredited by the American Diabetes Association, American Association of Diabetes Educators or the Indian Health Service)	
Glaucoma test -patient cost 20% after deductible	
Hepatitis B vaccine	
Hepatitis C screening test	
HIV screening	
Influenza vaccination	
Lung cancer screening - Low dose computed tomography (LD-CT) - This benefit may not yet be available in all locales as facilities must meet specific requirements to provide the service.	
Medical nutrition therapy for diabetes or kidney disease (provided by nutritionist or dietician)	
Obesity screening and intensive behavioral therapy	
Pneumococcal vaccination	
Prostate cancer screening - prostate specific antigen (PSA)	
Sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and/or Hepatitis B	
Sexually transmitted infection high intensity behavioral counseling	

Physician's signature: _____ Today's Date ____ / ____ / ____

1. Recommendation of American Cancer Society; see <http://www.uspreventiveservicestaskforce.org/3rduspstf/cervcan/cervcanrr.htm#clinical> for more information.