Orlando Internal Medicine

AWV Medicare Physical Questions

Patient Name: ______________________________ DOB: ______________________ DOS: ____________

To appear within the electronic Office Note: Initial Visit (G0438) or Subsequent (G0439), Medical History, Medication List review (1159F), List of Specialists, Family History and Vital Signs.

Functional Status Check: 1170F

Hearing:

Do you have trouble hearing the TV/Radio when others do not? ______________________________

Do you have to strain or struggle to hear/understand conversations? ____________________________

Cognitive Function Screening:

Do you live alone? YES NO

Do you need help getting dressed, bathing or walking? YES NO

Do you need help with preparing meals, transportation, shopping, taking your medicine, managing your finances?
YES NO

Home Safety Screening:

Does your home have rugs, poor lighting, or a slippery tub/shower? YES NO

Does your home have grab bars in bathrooms, handrails on stairs and steps? YES NO

Does your home have functioning Smoke Detectors? YES NO

Do you always fasten your seatbelt when you are in the car? YES NO

Fall Risk Screening: 3288F (assessment documented), 1100F (+ fall w/i the last year), 1101F (no falls)

Have you fallen two or more times in the past year? YES NO

Were you injured in any falls in the past year? YES NO

Was the patient unsteady or taking longer than 30 seconds during the timed "Timed Up and Go" test? (97750)

Tobacco Use: 4004F (user) or 1036F (nonuser)

Do you smoke? YES NO Have you ever been a smoker? YES NO

How long did you smoke? ____________ How many per day? ____________________

Alcohol Screening: G0442 (Use **CAGE** score within office note)

Do you drink alcohol? YES NO

- C: Have you ever felt you should **Cut** down on your drinking? YES(1) NO(0)
- A: Have people **Annoyed** you by criticizing your drinking? YES(1) NO(0)
- G: Have you ever felt **Guilty** about your drinking? YES(1) NO(0)
- E: Have you ever had a drink first thing in the morning (**Eye opener**) YES(1) NO(0)

Nutrition:

Are you on a special diet? YES NO

Advanced Care Planning: 99497

Do you have a Living Will or Advanced Directive? YES NO

Provider Initials: ____________

Patient Name: ______________________ DOB: ________________

Name of All Specialists/Doctors You See:	Speciality

Names of All Medications:	Doses and How Often You Take Them

Provider Initials: __________

Brief Pain Inventory (Short Form)

Study ID# ________ Hospital # ________

Do not write above this line.

Date: ________

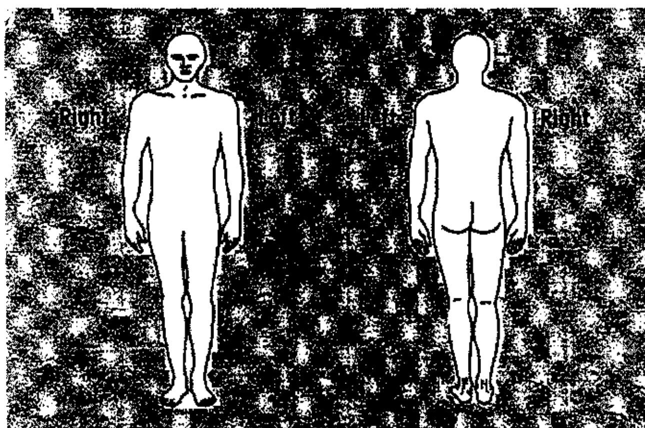
Time: ________

Name: ________
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

○ 1. yes ○ 2. no

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the **AVERAGE.**

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tell how much pain you have **RIGHT NOW.**

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

Save Print

7) What treatments or medications are you receiving for your pain?

____

8) In the past 24 hours, how much **RELIEF** have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No Relief — Complete Relief

9) Circle the one number that describes how, during the past 24 hours. **PAIN HAS INTERFERED** with your:

A. General Activity:

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

C. Walking Ability

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

D. Normal work (Includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

E. Relation with other people

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

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The Patient Health Questionnaire (PHQ-9)

Patient Name: ______________________________ **Date of Visit:** ______________

Practice Name: ORLANDO INTERNAL MEDICINE

Over the last 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 every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. 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
9. Thoughts that you would be better off dead or hurting yourself in some way.	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together ____________________

OIM Office Staff To Fill In:

Patient Name: ______________________________ DOB: ______________________

BMI: G8418 (below), G8420 (normal), G8417 (above) with ICD 10 Z68.XX, where XX = the BMI number)

Brief Pain Inventory: 1125F (normal), 1126F (pain present)

Codes	Measure	Recommendation	Scheduled/Completed
NEG: G8510; POS: G8431; DECLINED: G8433 (document reason)	DEPRESSION SCREENING (PHQ9)	YEARLY	
	VACCINES:		
DONE/PREV GIVEN: 4040F	PREVNAR 13	ONCE	
DONE/PREV GIVEN: 4040F	PNEUMOVAX 23	ONCE	
DONE/PREV GIVEN: G8482 EXC INC REASON: G8483 (decline included, document reason)	INFLUENZA	YEARLY	
	HEPATITIS B	ONCE	
	SHINGLES	NOT COVERED BY MCR	
	COVID 19		
REPORT REVIEWED: 3017F	COLORECTAL CANCER	FOBT-YEARLY; CT COLONOGRAPHY OR SIGMOIDOSCOPY Q4YRS; COLONOSCOPY Q10 YRS	
REPORT REVIEWED: G9899	BREAST CANCER	YEARLY	
	CERVICAL CANCER	YEARLY	
	PROSTATE CANCER	YEARLY	
	ABDOMINAL AORTIC ANEURYSM	SEE SPECIFIC REQUIREMENTS	
	DEXA SCAN (BONE MASS)	Q24MONS	
	LUNG CANCER SCREENING	YEARLY	
	HIV SCREENING	YEARLY- FOR HIGH RISK	
	GLAUCOMA EYE EXAM	YEARLY- FOR HIGH RISK	
	CARDIOVASCULAR LAB TESTS	Q5YEARS	
HbA1c <7.0%: 3044F; HbA1c 7.0-9.0%: 3045F; HbA1c > 9.0%: 3046F	DIABETES LAB TESTS	2X/YEAR IF PREDIABETIC	
2022F, 2024F, 2026F OR 3072F (PREV YEAR NEG) **REPORT NEEDED	DIABETIC RETINOPATHY	YEARLY OR ONCE PER 2 YEARS IF PREV YEAR WAS NEGATIVE	
SCREENED: 3066F OR THERAPEUTIC MON: 4010F	DIABETIC KIDNEY DZ SCREENING	MICROALBUMIN/CREAT CHECKED YEARLY	
SBP <140mmHg: G8752; SBP >=140mmHg: G8753; DBP <90mmHg: G8754; DBP >=90mmHg: G8755	CONTROLLED HYPERTENSION		
PTS RXD STATIN THERAPY:G9664; NOT APPROPRIATE: G9781	STATIN THERAPY FOR PREVENTION OF CVD		

Provider Initials: ______________