CLEVELAND MEDICAL ASSOCIATES, PLLC.

1060 WILLIAM WAY NW   CLEVELAND, TN 37312

Phone: (423) 478-1050 | Fax: (888) 853-7312

MEDICARE INITIAL PREVENTIVE PHYSICAL EXAMINATION ENCOUNTER FORM

PATIENT NAME: ____

DATE OF BIRTH: ______________________________ DATE OF EXAM:____________________________________

MEDICAL/SOCIAL HISTORY

Past personal illnesses or injuries:

Injury or Illness	Date	Hospitalized?

Family History Notes:

____

____

Medications/Supplements/Vitamins:

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____

List Drug Allergies:

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____

DO YOU DRINK ALCOHOL? **YES** **NO** IF **YES**, HOW MUCH? _______________________

DO YOU OR HAVE YOU EVER SMOKED, CHEWED, OR VAPED TOBACCO PRODUCTS? **YES** **NO**

IF **YES**, WHICH TYPE AND HOW OFTEN? ___________________________ IF **NO**, WHEN DID YOU QUIT? _______________

DO YOU OR HAVE YOU EVER USED ANY DRUGS? **YES** **NO**

IF **YES**, WHAT KIND(S) AND HOW OFTEN? __________________________ IF **NO**, WHEN DID YOU QUIT? _______________

DO YOU DO ANY FORM OF REGULAR EXERCISE EVERY DAY? **YES** **NO** IF **YES**, HOW MUCH? _______________

DEPRESSION SCREEN

OVER THE PAST TWO WEEKS, HAVE YOU FELT DOWN, DEPRESSED, OR HOPELESS? **YES** **NO**

OVER THE PAST TWO WEEKS, HAVE YOU FELT LITTLE INTEREST OR PLEASURE IN DOING THINGS? **YES** **NO**

FUNCTIONAL ABILITY/SAFETY SCREEN

WAS THE PATIENT'S TIMED UP & GO TEST UNSTEADY OR LONGER THAN 30 SECONDS? **YES** **NO**

DO YOU NEED HELP WITH THE PHONE, TRANSPORTATION, SHOPPING, PREPARING MEALS, HOUSEWORK, LAUNDRY, MEDICATIONS, OR MANAGING MONEY? **YES** **NO**

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**

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

HT: ___________ WT: ____________ BP: _____________ BMI: ____________ VISUAL ACUITY – L: ________ R: _______

ELECTROCARDIOGRAM

REFERRAL OR RESULT: ____

EVALUATIONS/REFERRALS BASED ON HISTORY, EXAM, AND SCREENING

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

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MEDICARE INITIAL PREVENTIVE PHYSICAL EXAMINATION ENCOUNTER FORM (Continued)

Service	Limitations	Recommendation	Scheduled
Vaccines -Pneumococcal -Influenza -Hepatitis B (if medium/high risk)	No deductible/no co-pay Medium/High-risk factors -End-stage renal disease -Patients with hemophilia who received Factor VIII or IX concentrates -Clients of institutions for the mentally retarded -Persons who live in the same house as a carrier of Hepatitis B virus -Homosexual man -Abuser of illicit injectable drugs		
Mammogram			
Pap and Pelvic Exams			
Prostate Cancer Screening -Digital rectal exam (DRE) -Prostate specific antigen (PSA)			
Colorectal Cancer Screening -Fecal occult blood test -Flexible sigmoidoscopy -Screening Colonoscopy -Barium enema	Exempt from Part B deductible		
Diabetes self-management training	Requires referral by treating physician for patient with diabetes or renal disease		
Bone mass measurements	Requires diagnosis related to osteoporosis or estrogen deficiency		
Glaucoma screening			
Medical nutrition therapy for diabetes or renal disease	Requires referral by treating physician for patient with diabetes or renal disease		
Cardiovascular screening blood tests -Total cholesterol -High-density lipoproteins -Triglycerides	Order as a panel if possible		
Diabetes screening tests -Fasting blood sugar (FBS) or glucose tolerance test (GTT)	Patient must be diagnosed with one of the following: -Hypertension -Dyslipidemia -Previous ID of elevated impaired FBS or GTT ….or any two of the following: -Overweight (BMI >25 but <30) -Family history of diabetes -Age 65 years or older -History of gestational diabetes or birth to baby weighing more than 9 pounds		
Abdominal aortic aneurysm screening -Sonogram			

Physicians Signature: ____ Date: ____________________