Patient (Last, First Name)	CIN #:	Gender	DOB	Age	Date of Service

ONECARE ANNUAL WELLNESS VISIT

CalOptima Health Adult D-SNP Members

ICD 10: Z00.00 ☐ In-person visit ☐ Telehealth (audio and video) visit

Annual Well Visit HCPC Codes	G0402 — Initial preventative physical exam (IPPE); face-to-face visit G0438 — AWV, includes a personalized prevention plan (PPS), **initial visit** G0439 — AWV, includes a personalized prevention plan (PPS), **subsequent visit** G0468 — Federally Qualified Health Center (FQHC) visit, IPPE/AWV

GENERAL PATIENT INFORMATION

History of Present Illness:

Vitals:

BP: _____ Repeat if > 140/90: _____	Pulse:	Temp:	SP O2:
Respiratory:	Height:	Weight:	BMI:

MEDICAL HISTORY

Advance Directive on file: ☐ Yes, Date:_____[1157F] ☐ No

Check all that apply below:

☐ Hypertension	☐ Seizures or convulsions	☐ Osteoporosis
☐ Congestive heart failure	☐ Rheumatoid arthritis	☐ Skin condition (ulcers/decubitus)
☐ Diabetes	☐ Myocardial infarction	☐ Stroke
☐ Cancer Type: _____ ☐ Currently in treatment ☐ Chemo ☐ XRT ☐ Adjuvant therapy ☐ In remission	☐ Past fracture: ☐ Vertebral ☐ Hip ☐ Wrist ☐ Other: _____	☐ Surgery (Type):_____ Date:_____
☐ COPD/chronic bronchitis ☐ Asthma ☐ Dependence on supplemental oxygen	☐ Liver disease or hepatitis ☐ Hepatitis B ☐ Hepatitis C	☐ Glaucoma/other eye problems Specify:
☐ Neuropathy	☐ Vascular disease ☐ Peripheral (claudication)	☐ Transplant; type: Date:
☐ Kidney disease ☐ Hemodialysis	☐ Ostomy: Site(s): _____	☐ Amputation (site): _____
☐ Hearing loss	☐ Transfusion Date:	☐ Recent hospitalization Date: _____ Reason: _____
☐ Other (specify):		

SOCIAL/BEHAVIORAL HISTORY

Check all that apply below:

Marital status:	Sexual activity: STDs:	☐ Suicidal ideation
☐ Depression/Bipolar disorder	☐ Dementia	☐ Schizophrenia

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SOCIAL/BEHAVIORAL HISTORY

Alcohol use: ☐ **Yes** ☐ **No** Amount _____ Frequency _____ ☐ Counseling/Referral:_____ _____	Drug use: ☐ Never ☐ Quit; Year_____ ☐ Current Type: _____ Amount _____ Frequency _____ ☐ Counseling/Referral:_____	Tobacco use: ☐ Never ☐ Current (Packs per day:_____) ☐ Quit ☐ Date/Year: _____ ☐ Pack-year history:_____ [1 pack year = Smoking 1 pack (20 cigarettes) per day for 1 year] ☐ Smoking cessation counseling

FAMILY HISTORY

Please indicate if any person, related by blood, has any of the following (Check all that apply):

Condition	Relationship	Condition	Relationship
☐ Hypertension		☐ Glaucoma	
☐ Stroke		☐ Cancer; type:	
☐ Coronary artery disease		☐ Alcoholism	
☐ High cholesterol		☐ Asthma	
☐ Diabetes		☐ Depression/suicide	

ALLERGIES

Medication allergies:		
1.	2.	3.
List other allergies:		
1.	2.	3.

LIST OF CURRENT PROVIDERS AND SUPPLIERS

1.	2.	3.
4.	5.	6.

LIST OF CURRENT MEDICATIONS

☐ **Reviewed/Reconciled 1160F** ☐ **Reviewed/Reconciled (within 30-day hospital post d/c 1111F)**
☐ **No current medications**

Please list all prescription/non-prescription medications with dosage/frequency:

1.	2.	3.
4.	5.	6.
7.	8.	9.
10.	11.	12.

REVIEW OF SYSTEMS

Please review with patient and check where applicable ☐ **None or N/A**

CONSTITUTIONAL:				
☐ Chills	☐ Daytime drowsiness	☐ Fatigue	☐ Fever	☐ Night sweats
EYES:				
☐ Wears glasses/contacts	☐ Cataracts	☐ Problems with vision		
EARS/NOSE/THROAT:				
☐ Hearing difficulty/loss	☐ Hearing aids	☐ Frequent earaches	☐ Ear discharge	☐ Ringing in ears (tinnitus)

Patient (Last, First Name)	CIN #:	Gender	DOB	Age	Date of Service

REVIEW OF SYSTEMS				
Please review with patient and check where applicable				**☐ None or N/A**
☐ Nasal blockage	☐ Sinus trouble	☐ Attacks of vertigo	☐ Frequent sore throat	☐ Snoring
☐ Sleep apnea	☐ Frequent sneezing	☐ Difficulty swallowing	☐ Recent change in voice	☐ Nose bleeds
HEART/CIRCULATION:				
☐ Chest discomfort (angina)	☐ Shortness of breath w/ activity	☐ Blood clot in artery/vein	☐ Heart surgery	☐ Blackout spells
☐ Heart murmur				
RESPIRATORY:				
Cough☐	☐ Shortness of breath	☐ Coughing up blood		
STOMACH/INTESTINES:				
☐ Ulcer	☐ Hiatal hernia	☐ Poor appetite	☐ Frequent heartburn/indigestion	☐ Acid reflux
☐ Blood from bowels/rectum	☐ Gall bladder attacks/gallstones	☐ Frequent diarrhea	☐ Abnormal stool	☐ Constipation
KIDNEYS/URINARY TRACT:				
☐ Bladder infections in past year	☐ Frequent night urination	☐ Kidney stones/infection	☐ Trouble starting urinary stream	☐ Pain/burning w/ urination
☐ Blood in urine in past year				
ENDOCRINE/METABOLISM:				
☐ Unusual hair loss/growth				
BLOOD:				
☐ Bleeding/bruising tendency				
NERVOUS SYSTEM:				
☐ Headache/migraine				
SKIN:				
☐ Rash/psoriasis/dermatitis	☐ New skin growth or mole	☐ Ulcer site: _____		
MUSCLES/BONES/JOINTS				
☐ Chronic back trouble	☐ Arthritis/other joint disease			
ALLERGY:				
☐ Anaphylaxis	☐ Food intolerance	☐ Itching	☐ Nasal congestion	☐ Rash
PSYCHOLOGICAL:				
☐ Loss/change in appetite	☐ Behavioral change	☐ Confusion	☐ Insomnia	☐ Memory loss
☐ Mood change				
MEN:				
☐ Testicular swelling	☐ Prostate problems	☐ Frequent urination		
WOMEN:				
☐ Painful periods	☐ Excessive flow	☐ Irregular cycles	☐ Vaginal burning	☐ Hot flash/menopause symptoms
☐ Currently pregnant?				

Patient (Last, First Name)	CIN #:	Gender	DOB	Age	Date of Service

PHYSICAL EXAM

NL = Normal ABN = Abnormal

Area:	**NL**	**ABN**	**Describe Findings if Abnormal**	**Area:**	**NL**	**ABN**	**Describe Findings if Abnormal**
General	☐	☐		Pelvic	☐	☐	
Skin	☐	☐		Musculoskeletal	☐	☐	
HEENT	☐	☐		Neurologic	☐	☐	
Neck/Thyroid	☐	☐		Vascular	☐	☐	
Heart	☐	☐		Lymphatic	☐	☐	
Lungs	☐	☐		Extremities	☐	☐	
Breast	☐	☐		Prostate	☐	☐	
Abdomen	☐	☐		Rectal	☐	☐	

DIAGNOSTIC ASSESSMENT AND PLANS

Please document member’s chronic conditions, statuses and treatment plan as appropriate

Diagnosis Description	**Assessment**	**Plan**
	☐ Stable ☐ Improved ☐ Worsened ☐ Other:	
	☐ Stable ☐ Improved ☐ Worsened ☐ Other:	
	☐ Stable ☐ Improved ☐ Worsened ☐ Other:	
	☐ Stable ☐ Improved ☐ Worsened ☐ Other:	
	☐ Stable ☐ Improved ☐ Worsened ☐ Other:	
	☐ Stable ☐ Improved ☐ Worsened ☐ Other:	
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	☐ Stable ☐ Improved ☐ Worsened ☐ Other:	
	☐ Stable ☐ Improved ☐ Worsened ☐ Other:	
	☐ Stable ☐ Improved ☐ Worsened ☐ Other:	
	☐ Stable ☐ Improved ☐ Worsened ☐ Other:	

Patient (Last, First Name)	CIN #:	Gender	DOB	Age	Date of Service

SCREENINGS AND ASSESSMENTS

ANNUAL PREVENTIVE SERVICES AND TESTS FOR DIABETICS

☐ **GFR, estimated** [82565] (serum creatinine) Date: Result:	☐ **Microalbumin/creatinine ratio** [82042] Date: Result:
A1C test [83036] (at least twice/year) Date: Result: ☐ Most recent A1C ≥7% and ≤ 8% (DM) [3051F] ☐ Most recent A1C ≥8% and ≤ 9% (DM) [3052F]	**LDL-cholesterol** [80061] Date: Result:
Retinal eye exam [2022F] Result: ☐ Normal ☐ Positive retinopathy_____ Date: _____	☐ **Foot exam w/ monofilament test** [G8404] Date: Result:

OTHER PREVENTIVE SERVICES/TESTS
(Check test performed, date performed)

☐ Flu vaccine in current season (all members) [G8482] Date: _____ ☐ Pneumonia vaccine (50+ years) [G8864] Date:_____ ☐ Shingles vaccine (age 50+ years): [90750] Date Dose 1_____ Date Dose 2_____ ☐ Updated annual COVID-19 vaccine (2 doses if >65 yrs) Date_____ ☐ RSV vaccine one time (>75 yrs or high risk 60–74 yrs) Date_____	**Pt with cardiovascular condition**: ☐ LDL-C test Date: _____ Result: _____ ☐ Most current LDL-C value is <100mg/dL ☐ Low-dose chest CT scan annually (age 50–77 yrs with 20 pack-years smoking hx) Date:_____ ☐ AAA one time (65–75 yrs men w/any smoking hx) Date:_____ ☐ Hepatitis C screen one time (18–79 yrs) Date_____
Colorectal Screening (age 45 to 75 yrs) ☐ FOBT [82270] (annual); Date:_____ ☐ Colonoscopy [44388] (every 10 yrs); Date:_____ ☐ Cologuard (every 3 yrs) Date: _____ ☐ Other test: _____Date: _____	Osteoporosis Screening ☐ Dexa Scan (Women 65+) (Annual) [77080] Date: _____ ☐ Dexa Scan (Women) (Bone fx in last 12 mos) [G8399] Test date: _____ Last Rx Date: _____
Breast Cancer Screening [77067] (biannual) Mammogram (age 40–74) Date_____ Results: _____	Cervical Cancer Screening [87624] Date: _____ Results: _____
Prostate Cancer Screening [G0103] (men 55–69 yrs individualized decision) Date: _____ Results: _____	Other:

[0521F]

PAIN ASSESSMENT

Pain assessment scale 0–10: [1125 F (+ pain), 1126F (no pain)]
(0 = No pain to 10 = Worst pain)
Location of pain: _____ Level: _____ Location of pain: _____ Level: _____

Patient (Last, First Name)	CIN #:	Gender	DOB	Age	Date of Service

FUNCTIONAL STATUS / ACTIVITIES OF DAILY LIVING (ADLs)

Check all that apply below: **[1170F/G8539]**

Transportation: ☐ Drives self ☐ Driven by others ☐ Bus/Taxi ☐ Other: _____ ☐ None	**Ambulation:** ☐ Walk without assistance ☐ Walker ☐ Cane ☐ Partial ☐ Completely wheelchair dependent ☐ Bedridden ☐ Problems with balance
Ability to take medication by self: ☐ Yes ☐ No	**Risk for Falls:** ☐ Yes; [If yes, discussed w/ patient in last 12 months? ☐ Yes ☐ No] ☐ No
Ability to prepare food: ☐ Yes ☐ No **Ability to feed self:** ☐ Yes ☐ No	**Caregivers:** ☐ Self ☐ None ☐ Has caregiver ☐ IHSS ☐ Other:
Grooming: ☐ Yes ☐ No	**Marital Status:** ☐ Married ☐ Divorced ☐ Single
Toileting: ☐ Yes ☐ No	**Homelessness:** ☐ Yes ☐ No
Bladder incontinence: ☐ **Yes (if Yes):** ☐ Discussed with patient OR ☐ Put on Tx during last 6 months? ☐ Yes ☐ No ☐ **No**	**Risk of placement to SNF:** ☐ Yes ☐ No If yes, reason:
Risk of admission to hospital: ☐ Yes ☐ No If yes, reason:	**Exercise:** ☐ Yes; type/frequency:_____ ☐ No; discussed exercise program w/patient: ☐ Yes ☐ No
Other concerns:	

DEPRESSION SCREENER (PHQ-9)

Over the last two weeks, how often have you been bothered by 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 of hurting yourself in some way**	☐ 0	☐ 1	☐ 2	☐ 3
FOR OFFICE CODING				
Each column total	____	____	____	____
SCORING TOTAL (sum of all columns)	**Total: _____**			
SCORE INDICATOR	☐ **<10**		☐ **>=10 indicates major depression**	

Patient (Last, First Name)	CIN #:	Gender	DOB	Age	Date of Service

DEPRESSION SCREENER (PHQ-9)				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	☐ Not at all	☐ Somewhat difficult	☐ Very difficult	☐ Extremely difficult

PHQ-9 SCORING		
PHQ-9 Score	**Depression Severity**	**Proposed Treatment Actions**
0–4	None-minimal	None
5–9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10–14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15–19	Moderately severe	Active treatment with pharmacotherapy and/or psychotherapy

COGNITIVE FUNCTIONING [65+ years annually]	
Check all that apply below: [96156 or 96158, 96159]	
Oriented: ☐ Yes ☐ No	Memory deficit: ☐ Yes ☐ No
Immediate recall: ☐ Good ☐ Poor	Inappropriate behavior: ☐ Yes ☐ No
Delay recall: ☐ Good ☐ Poor	Confused: ☐ Mostly ☐ At times ☐ Not at All
Mini-Cog scores if given (see attached for tool): Clock Drawing:_____Memory: _____	

The MINI-COG TEST

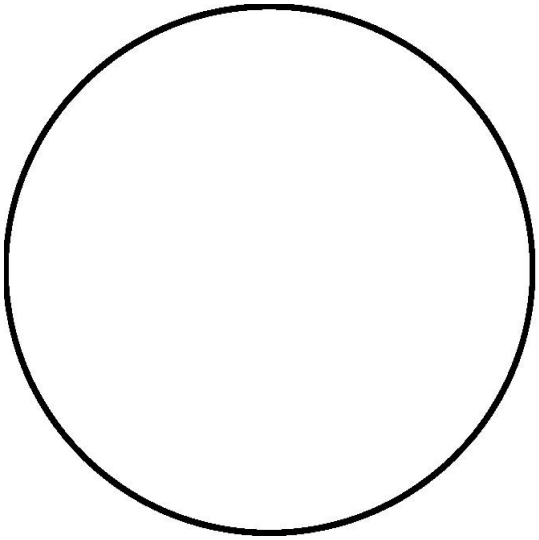
1. **Instruct the patient to listen carefully and repeat the following:**

APPLE	WATCH	PENNY
MANZANA	RELOJ	PESETA

2. **Administer the Clock Drawing Test**
   Clock Drawing Instructions

   Inside the circle, draw the hours of a clock as if a child would draw them. Place the hands of the clock to represent the time "forty-five minutes past ten o'clock."

   Dentro del círculo dibuje las horas del reloj como si lo haría un niño. Ponga las manos del reloj para representar el tiempo "cuarenta y cinco minutos despues de las di



Patient (Last, First Name)	CIN #:	Gender	DOB	Age	Date of Service

The MINI-COG TEST

3. **Ask the patient to repeat the three words given previously:**

_____ _____ _____

PROVIDER NAME AND CREDENTIALS (PRINT)	PROVIDER SIGNATURE	DATE