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:

Injury or illness	Date	Hospitalized?

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): _____

_____

_____

continued ➤

MEDICARE INITIAL PREVENTIVE PHYSICAL EXAMINATION ENCOUNTER FORM continued

Create two copies of this page: one for your charts and one to give to your patient.

COUNSELING AND REFERRAL OF OTHER PREVENTIVE SERVICES

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 men • Abusers 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 • Obesity (BMI ≥30 kg/m^2) • 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	Patient must be referred through IPPE and not have had a screening for abdominal aortic aneurysm before under Medicare. Limited to patients who meet one of the following criteria: • Men who are 65-75 years old and have smoked more than 100 cigarettes in their lifetime • Anyone with a family history of abdominal aortic aneurysm • Anyone recommended for screening by the U.S. Preventive Services Task Force		

Physician's signature: _____ Date: _____

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