Patient Name: _____________________________DOB: _______________Today's Date: _______________
Last, First, MI

MEDICARE PREVENTIVE PHYSICAL EXAM

☐ Initial Preventive Physical Exam (Welcome to Medicare Physical) G0402	☐ Initial annual wellness visit G0438	☐ Subsequent annual wellness visit G0439
Medicare Part B Eligibility Date:	Date of Last Exam:	Date of Last IPPE or AWV:

Vital Signs					
Ht:	Wt:	BMI or Waist:	BP:	Temp:	P/R:

Social History	
Tobacco ☐ Current Type: Freq: ☐ 2nd hand ☐ Never ☐ Prior use Quit date:	
Alcohol ☐ Never ☐ Occasional ☐ Daily History of alcohol: (describe)	
Diet Notes	Caffeine ☐ Never ☐ Occasional ☐ Daily
Drug abuse ☐ Never ☐ Occasional ☐ Daily ☐ Prior use ☐ Quit date: History of drug abuse: (describe)	
Occupation	Exercise type/ frequency
Home environment ☐ Private home ☐ Assisted living ☐ Other: (describe)	
Do you drive? ☐ Yes ☐ No	Do you use seat belts? ☐ Yes ☐ No

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									
Liver disease									
Depression or manic depressive order									
Colon or rectal cancer									
Breast cancer									
Other cancer									
Other: _____________									

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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)

Preventive Screenings Have you had any of the following?	
Breast cancer (women only) ☐ Yes ☐ No Date	Prostate cancer (men only) ☐ Yes ☐ No Date
Colon cancer ☐ Yes ☐ No Date	Cholesterol ☐ Yes ☐ No Date
Glaucoma eye exam ☐ Yes ☐ No Date	

Immunizations		
Have you had a flu vaccine within the past year?	☐ Yes	☐ No
Have you had a pneumonia shot?	☐ Yes	☐ No
Have you had a shingles vaccination?		
When was your last tetanus/ diphtheria shot?	Date	

Broken Bones/ Falls	
Have you broken a bone? ☐ Yes ☐ No	Had a bone mineral density test? ☐ Yes ☐ No
Fallen within the past year? ☐ Yes ☐ No	
If you have fallen within the past year, how many times?	

Bladder/ Bowel		
In the past six months, have you accidentally leaked urine?	☐ Yes	☐ No
Do you have problems with loss of bowel control?	☐ Yes	☐ No

Home Safety		
Do you have trouble with the stairs inside or outside your home?		
Do you have hazards inside the home such as a lack of grip bars in the bath tub, loose rugs or poor lighting?	☐ Yes	☐ No
Does your home have working smoke alarms?	☐ Yes	☐ No
Does your home have a carbon monoxide monitor?	☐ Yes	☐ No

Nutrition In the past 7 days:	
How many servings of fruit and vegetables did you typically eat each day?	*serving(s)/day*
How many servings of high-fiber foods or whole grains did you typically eat each day?	*serving(s)/day*
How many servings of fried or high-fat foods did you typically eat each day?	*serving(s)/day*
How many sugar-sweetened beverages did you typically consume each day?	*serving(s)/day*

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Activities of Daily Living Can you:					
Get out of bed yourself?	☐ Yes	☐ No	Dress yourself?	☐ Yes	☐ No
Make your own meals?	☐ Yes	☐ No	Do your own shopping?	☐ Yes	☐ No
Do your laundry/ housekeeping?	☐ Yes	☐ No	Bathe yourself?	☐ Yes	☐ No
Manage your money, pay your bills and track your expenses?				☐ Yes	☐ No
Take your medication as directed by your doctor?				☐ Yes	☐ No

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

Problem List				
Chronic problems	Date added	Managing physician (if other)	Date updated	Initial

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

General Health How would you rate your general health?	
Overall health	◻ Excellent ◻ Very good ◻ Good ◻ Fair ◻ Poor
Physical health *(compared to last year)*	◻ Much better ◻ Slightly better ◻ Same ◻ Slightly worse ◻ Much worse
Eyesight *(compared to last year)*	◻ Same ◻ Slightly worse ◻ Much worse
Hearing *(compared to last year)*	◻ Same ◻ Slightly worse ◻ Much worse
Emotional health *(compared to last year)*	◻ Much better ◻ Slightly better ◻ Same ◻ Slightly worse ◻ Much worse
Pain: In the past 7 days, how much pain have you been you experienced?	◻ None ◻ Some ◻ A lot
If you answered "Some" or "A lot," please rate the severity of your pain on a scale of 1 to 10. *(1 being the least severe pain and 10 being the most intense pain; circle one)* 1 2 3 4 5 6 7 8 9 10	
Weight: In the past 6 months, have you lost or gained 10 pounds without trying?	◻ Yes ◻ No