Primary Care Associates of California Medical Group
PCAC

ANNUAL HEALTH ASSESSMENT FORM

Date:	Name:	DOB:	Health Plan:
Temp:	BP: HR:	Ht: Wt:	BMI:
Gender: ☐ Male ☐ Female		**Allergies:**	
PCP:		Marital Status:	Education Level:
Immuni_ation Records ACIP : ☐ Yes ☐ No		Work History:	

Measurement Qualification/codes	**Description**	**Codes in ()**	**Bolded are control**

✓ *FOR ALL THE SENIOR PATIENTS include order or capture date no pending please*

1. Flu Vaccine (All ages yearly)	Date of vaccination: _____/_____/20___ (G0008) or previously (G8482)
2. Pneumococcal Vaccine (Age > 60)	Date of vaccination: _____/_____/20___ (G0009) or previously (4040F)
3. Colon Cancer Screening (Age 50-75) Colonoscopy Q10 years or Sigmoidoscopy Q5 years or FOBT annually ICD- Z12.11	Check one ☐ Colonoscopy (G0105) ☐ Sigmoidoscopy (G0104), ☐ FOBT (G0328) Screening date: _____/_____/_____, Results ☐ Normal ☐ Abnormal ☐ Polyp Or ☐ Not applicable (due to h/o Colon Cancer or s/p colectomy). Approximate dates are acceptable but year is mandatory. Please record date in chart.
4. Female Breast Cancer Screening (Age 40-74) Q2 yrs, ICD- Z12.31	Mammogram date: _____/_____/_____, (G0202) Or ☐ Not applicable due to (s/p bilateral mastectomy or history of Breast CA)
5. HTN control, last BP < 140/90 mm Hg (Age 18-85, Q yr.) (3074F-3078F)	Last BP reading: _____/_____mm Hg, Date measured: _____/_____/20___ Must have diagnosis of HTN on progress note.
6. BMI/ Obesity (Age 18-74 annually)	BMI = _____ Date: _____/_____/20___ (3008F) Z68.__ __
7. Osteoporosis: Females Age 65-85 years, who suffered a fracture	Bone Density Scan Date: _____/_____/_____
Diagnosis for RA Verified? No Yes Exclude due to diagnosis of HIV Positive.	If yes: Prescribed or current disease-modifying antirheumatic drug (DMARD) Date: _____/_____/20___

✓ *Care of Older Adults (COA)*

8. Medication List	☐ YES	Date: _____/_____/20___	☐ **CODE: 1159F**
9. Medication List Reviewed	☐ YES	Date: _____/_____/20___	☐ **CODE: 1160F**
10. Pain Assessment: Does the member have any pain?	☐ YES	Date: _____/_____/20___ Location: _____	☐ **CODE: 1125F**
	☐ NO	Date: _____/_____/20___	☐ **CODE: 1126F**
11. Functional Status Assessment: Activities of daily living were assessed	☐ YES	Date: _____/_____/20___	☐ **CODE: 1170F**
12. Advance Directives on file? If not, discussed with patient:	☐ YES	Date: _____/_____/20___	☐ **CODE: 1157F**
	☐ YES	Date: _____/_____/20___	☐ **CODE: 1158F**

✓ *Does the member have DIABETES? if not skip, bolded codes are controlled ages 18-75 annually, mark the date test captured or ordered, no pending*

13. Last LDL LESS THAN 100 mg/dl (3048F-3050F)	Last LDL: _____ mg/dl, Lab date: _____/_____/20___
14. Diabetic Retina Exam (2022F-2026F, 2033F, 3072F)	Date performed by optometrist or opthalmologist:_____/_____/20___ Optometrist or Opthalmologist Name: _____
15. Last HgA1C LESS THAN 9.0% (3044F, 3051F, 3052F, 3046F)	Last HgA1C: _____ %, Lab date: _____/_____/20___
16. Microalbuminuria (3061F, 3062F) Or is pt. on an ACE or ARB	Lab date: _____/_____/20___, Result: ☐ (+) ☐ (-) Or ☐ Yes on ACE or ARB _____ Date: _____/_____/20___
17. Blood pressure reading LESS THAN 140/90 mm Hg, (3074F-3078F)	Last BP reading::_____/_____ mm Hg, Date measured: _____/_____/20___

I certify that I have performed all the services listed above and on the next page as they are applicable to this member and all the results have been documented in the member's chart. I understand that if I submit information for a measure that is incomplete it will not be counted by PCAC IPA and associated Health Plan.

⇨ **Provider Signature:** _____ **Date:** _____

Pt. Name: _____ Pt. DOB: _____

✓ *Medication Management*		
18. Statin Treatment for Diabetes (Age 40-75, Q1 Yr) (Only for members with DM)	Is member currently taking a statin? ☐ YES ☐ NO (If Member has DM, member should be on statins) QT 90-100 x 3 Prescribed? ☐ YES ☐ NO	Statins use inappropriate for this member ☐ YES ☐ NO
19. Statin Treatment for Cardiovascular Disease (Males Age 21-75, & Females Age 40-75, Q1 Yr)	Is member currently on a statin? ☐ YES ☐ NO (Only for members with CVD) QT 90-100 x 3 Prescribed? ☐ YES ☐ NO	Statins use inappropriate for this member ☐ YES ☐ NO
20. RAS Antagonists Adherence (Age 18 & Older, Q1 Yr)	Has this member been educated? QT 90-100 x 3 Prescribed? ☐ YES ☐ NO	
21. Oral Diabetic Medication (Age 18 & Older)	Has this member been educated? QT 90-100 x 3 Prescribed? ☐ YES ☐ NO	
22. Statin Adherence (Age 18 & Older, Q1 Yr)	Has this member been educated? QT 90-100 x 3 Prescribed? ☐ YES ☐ NO	

FUNCTIONAL STATUS ASSESSMENT: ☐ **CODE 1170F**

✓ Transportation: Drives self ☐ Bus ☐ Taxi ☐ Driven by others ☐
✓ Ability to administer medication to self: Yes ☐ No ☐
✓ Housework: Yes ☐ No ☐
✓ Ability to prepare and serve own food: Yes ☐ No ☐
✓ Grocery shopping: Yes ☐ No ☐
✓ Laundry: Yes ☐ No ☐
✓ Ambulation: Walks on own ☐ Walks with assistance ☐ Walker ☐ Cane ☐ Partial with dependence ☐
✓ Completely dependent ☐ Bedridden ☐

COGNITIVE FUNCTION ASSESSMENT:

✓ Oriented and alert: Yes ☐ No ☐
✓ Memory deficit: Yes ☐ No ☐
✓ Immediate recall: Yes ☐ No ☐

PHQ9 Depression screening questionnaire Date _____/_____/2020 **Over the past 14 days, how often have you experienced any of the following problems?**	**Not at all 0**	**< week 1**	**> week 2**	**Daily 3**
1. Feeling down, depressed, hopeless, and helpless.				
2. Having little interest or pleasure in doing daily activities.				
3. Feeling tired or having a little or no energy.				
4. Trouble falling or staying asleep, or sleeping too much.				
5. Trouble concentrating or doing things such as reading the newspaper or magazines or TV.				
6. Feeling bad about yourself, Thinking that you're a failure or have let yourself or your family down.				
7. Poor appetite or over eating.				
8. Moving or speaking slowly than others that have been noticed. Or being restless, fidgety and moving around more than usual.				
9. Thoughts that you are better off dead or hurting yourself in some way.				

Total _____ / 27 _____

0-4 no depression 5-9 mild depression 10-14 Moderate depression 15-19 Moderate to severe depression 20-27 Severe depression

PHQ9 Score <10_____>_____

⇨ **Provider Signature:** _____ **Date:** _____

Pt. Name: _____ Pt. DOB: _____

Chief Complaints / History of Present illness:

_____

_____

Current Medications & dosage:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Family History:

	Father	Mother	Children	Siblings	Grandparents
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐

Past Medical History: _____

_____

Social History:

Eduation Provided

☐ Drug Abuse/Dependence _____ ☐ Alcohol Abuse/Dependence _____ ☐

☐ Smoking: ☐ Past _____ ☐ Current, # of pack _____ ☐

☐ Pap Smear ☐ Sexual History _____ ☐ High-risk lifestyle _____ ☐

☐ Nutrition Counseling

Surgical History:

Procedure	Reason for Procedure	Date	Surgeon or facility
_____	_____	_____	_____
_____	_____	_____	_____

Review of Systems:

General Appearance:

_____

_____

Eyes:

_____

_____

Ear, nose, mouth, throat, neck:

_____

_____

Cardiovascular:

_____

_____

Respiratory:

_____

_____

Gastrointestinal:

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_____

Urinary:

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Skin:

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Neurological:

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_____

Lymphatic:

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_____

Physical Exam:

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Providers involved with care specialists/suppliers:

_____

_____

_____

Prostate Cancer Screening: _____ Date __/__/___

Lung Cancer Screening: _____ Date __/__/____

Cervical/Vaginal Cancer Screening: ____ Date __/__/____

STD Screening: _____ Date __/__/____

TB Test: _____ Date __/__/____

Abdominal Aneurysm Screening: _____ Date __/__/____

HEP B Screening: _____ HEP C Screening: _____

WBC: _____ Hgb: _____ Hct: _____

Plt: _____ GFR: _____ HgA1c: _____

PSA: _____

Date of lab: _____/_____/_____

⇨ **Provider Signature:** _____ **Date:** _____

Pt. Name: _______________ Pt. DOB: ___________

Code if Present:		☐ Active/Stable ☐ Acute ☐ Declining ☐ Resolved	Plan: Current Rx:
Code if Present:		☐ Active/Stable ☐ Acute ☐ Declining ☐ Resolved	Plan: Current Rx:
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Code if Present:		☐ Active/Stable ☐ Acute ☐ Declining ☐ Resolved	Plan: Current Rx:
Provider Signature and Credential:		(Check one) ☐ MD ☐ DO ☐ NP ☐ PA ☐ Other Date:	

⇨ **Provider Signature:** ______________________________ **Date:** ______________