Sweetwater Medical Associates

Initial Preventive Physical Examination (IPPE)

aka the Welcome to Medicare Preventive Visit

The goals of the IPPE are health promotion, disease prevention and detection. This is not a routine annual physical. Medicare pays for one IPPE per beneficiary per lifetime within the first 12 months of the effective date of becoming active on Medicare Part B.
Filling out this form before your visit will assist your provider with preventive recommendations.

General Information:

Member Name: _____

D.O.B.: _____

Primary Care Physician: Dr. Alford Dr. Shaffer Dr. White
(Circle one)

Current Medications:

Medication	Dose	Last Refill Date	Reason/Dx

Supplements/Vitamins	Dose	Duration/Frequency

Other/Illegal Drugs	Dose	Duration/Frequency

Opioid Risk Tool/Illicit Drugs:

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals *(For Office Use Only)*		

Physical Activity & Nutrition:

Do you exercise on a regular basis? (*Circle*) Yes No

If yes, _____ times a week for _____ mins.

Types of exercise: *(Circle)* Walking Weights Floor exercises
Running Swimming Other _____
Aerobics Zuma Other _____

Do you understand how regular exercise can benefit you? (*Circle*) Yes No

In a typical Week:

How many servingsof fruits and vegetables do you eat each day? _____ servings/day

How many servings of high fiber or whole grains do you eat daily? _____ servings/day

How many servings fo fried or high-fat foods do you eat daily? _____ servings/day

How many sugar-sweetened (not diet) beverages do you drink daily? _____ sugar sweetened drinks/day

Advance Directive Documentation/Education:

Do you have an advance directive? *(Circle)* Yes No

If yes, bring a copy of it or document the name of the Provider that has your Advance Directive:

_____

Fall Risk Assessment:

How many times have you fallen in the last 12 months? (Circle) 1 2 3+

If you have fallen, did you sustain any injuries: (Circle) Yes No

Whay types of injuries did you have? _____

_____

Were you hospitalized? (Circle) Yes No

Hearing Impairment:

Please **circle** YES, SOMETIMES, OR NO to each of the following items. Please do not skip a question. If you have a hearing aid, please answer the way you hear without the aid.

E-1. Does a hearing problem cause you to feel embarrassed when meeting new people?	YES	SOMETIMES	NO
E-2. Does a hearing problem cause you to feel frustrated when talking to members of your family?	YES	SOMETIMES	NO
S-3. Do you have difficulty hearing when someone speaks in a whisper?	YES	SOMETIMES	NO
E-4. Do you feel handicapped by a hearing problem?	YES	SOMETIMES	NO
S-5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	YES	SOMETIMES	NO
S-6. Does a hearing problem cause you to attend religious services less often than you would like?	YES	SOMETIMES	NO
E-7. Does a hearing problem cause you to have arguments with family members?	YES	SOMETIMES	NO
S-8. Does a hearing problem cause you difficulty when listening to TV or radio?	YES	SOMETIMES	NO
E-9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	YES	SOMETIMES	NO
S-10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	YES	SOMETIMES	NO

For Provider Use Only:

Total Score:_____
Subtotal E: _____
Subtotal S: _____

Activities of Daily Living:

Mark with a "x"

Activity	No Help Needed *(2 pts. Each)*	Need Some Help *(1 pt. each)*	Unable to Do At All *(0 pts. Each)*
1. Using the telephone			
2. Getting to places beyond walking			
3. Grocery shopping			
4. Preparing meals			
5. Doing housework or handyman			
6. Doing laundry			
7. Taking medications			
8. Managing money/bills			
Total Score: _____ = *(For Office Use Only)*	*(___x 2 =) ___ +*	*(____x 1 =)____ +*	*0*

Home Safety:

Do you have good lighting inside and outside your home? *(Circle)*			Yes	No
Do you have handrails on stairs? *(Circle)*	Yes	No		
Do you have handrails in bathtub/shower? *(Circle)*		Yes	No	Not Needed

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 figety 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	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. 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 difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

The AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization and the Generalitat Valenciana Conselleria De Benestar Social. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at www.who.org.