Flatiron Internal Medicine
Caring. Comprehensive. Wellness.

Preventative Visit Insurance Coverage Form

You are scheduled for an annual physical. A routine annual physical is a preventive health visit you receive when you are symptom-free and includes routine labs and basic screenings.

Generally, the majority of insurance companies cover this visit at 100% with no member responsibility.

Your insurance coverage for a routine physical visit is different than your insurance coverage for an office visit.

The annual routine physical coverage provided by your insurance company does not include payment for services rendered for an illness, or related to other specific acute or chronic conditions.

While your appointment may be originally scheduled for a routine annual physical, if services are provided for other non-routine issues, an additional problem-related code may be billed.

We are legally obligated to assign procedure codes based on the services we provided to you, regardless of whether it was for an annual physical, a visit to address chronic or acute issues, or a combination of both.

We hope that this explanation will enhance your understanding, in advance of your appointment, of any future financial responsibility.

Kindly sign below to acknowledge your understanding of the above. Thank you.

_____ _____

Patient Name Printed Date of Birth

_____ _____

Patient Signature Today's Date

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Review of Systems Form

Patient Name: _____ Appointment Date: _____

Please indicate if you are experiencing any of the following:

Constitutional		
☐ Please check if all negative		
Negative	Positive	
		Chills
		Fatigue
		Fever
		Malaise
		Night sweats
		Weight gain
		Weight loss
Comments/Other:		

Head, Ear, Eyes, Nose, Throat		
☐ Please check if all negative		
Negative	Positive	
		Ear drainage
		Ear pain
		Eye discharge
		Eye pain
		Hearing loss
		Nasal drainage
		Sinus pressure
		Sore throat
		Visual changes
Comments/Other:		

Respiratory		
☐ Please check if all negative		
Negative	Positive	
		Chronic cough
		Cough
		Known TB exposure
		Shortness of breath
		Wheezing
Comments/Other:		

Cardiovascular		
☐ Please check if all negative		
Negative	Positive	
		Chest pain
		Leg/Ankle pain (Claudication)
		Leg/Ankle swelling (Edema)
		Palpitations
Comments/Other:		

Gastrointestinal		
☐ Please check if all negative		
Negative	Positive	
		Abdominal pain
		Blood in stools
		Change in stools
		Constipation
		Diarrhea
		Heartburn
		Loss of appetite
		Nausea
		Vomiting
Comments/Other:		

Genitourinary		
☐ Please check if all negative		
Negative	Positive	
		Dribbling (Males)
		Painful urination (Dysuria)
		Blood in urine (Hematuria)
		Excessive urination (Polyuria)
		Slow stream
		Urinary frequency
		Urinary incontinence
		Urinary retention
Comments/Other:		

Male Reproductive		
☐ Please check if all negative		
Negative	Positive	
		Erectile function concerns
		Penile discharge
		Sexual function concerns
Comments/Other:		

Female Reproductive/Breast		
☐ Please check if all negative		
Negative	Positive	
		Abnormal Pap
		Pain during menstruation (Dysmenorrhea)
		Painful intercourse (Dyspareunia)
		Hot flashes
		Irregular menses
		Vaginal discharge
		Breast discharge
		Breast lump
Comments/Other:		

Review of Systems Form (Continued)

Patient Name: _____ Appointment Date: _____

Metabolic/Endocrine		
☐ Please check if all negative		
Negative	Positive	
		Cold intolerance
		Heat intolerance
		Excessive thirst (Polydipsia)
		Excessive hunger (Polyphagia)
Comments/Other:		

Neurological		
☐ Please check if all negative		
Negative	Positive	
		Dizziness
		Extreme numbness
		Extremity weakness
		Gait disturbance
		Headache
		Memory impairment
		Seizures
		Tremors
Comments/Other:		

Psychiatric		
☐ Please check if all negative		
Negative	Positive	
		Anxiety
		Depression
		Insomnia
Comments/Other:		

Integumentary		
☐ Please check if all negative		
Negative	Positive	
		Brittle hair
		Brittle nails
		Hair loss
		Unwanted, male-pattern hair growth in females (Hirsutism)
		Hives
		Itching (Pruritus)
		Mole changes
		Rash
		Skin lesion
Comments/Other:		

Musculoskeletal		
☐ Please check if all negative		
Negative	Positive	
		Back pain
		Joint pain
		Joint swelling
		Muscle weakness
		Neck pain
Comments/Other:		

Hematologic/Lymphatic		
☐ Please check if all negative		
Negative	Positive	
		Easy bleeding
		Easy bruising
		Swollen lymph nodes (Lymphadenopathy)
Comments/Other:		

Immunologic		
☐ Please check if all negative		
Negative	Positive	
		Contact allergy
		Environmental allergies
		Food allergies
		Seasonal allergies
Comments/Other:		

Advance Directive		
Yes	No	
		Do you have a living will?
Name of durable power of attorney		

Additional Comments:

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 ☐

Name:_____ Date:_____ Date of Birth:_____

A Checklist for Your Medicare Wellness Annual Visit

Please complete this checklist before seeing your doctor or nurse. Your answers will help you receive the best health care possible.

1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

2. During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors or groups?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

3. During the past 4 weeks, how much bodily pain have you generally had?
   - ☐ No pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain

4. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.
   - ☐ Yes, as much as I wanted
   - ☐ Yes, quite a bit
   - ☐ Yes, some
   - ☐ Yes, a little
   - ☐ No, not at all

5 During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
   - ☐ Very heavy
   - ☐ Heavy
   - ☐ Moderate
   - ☐ Light
   - ☐ Very light

	Yes	No
6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?	☐	☐
7. Can you shop for groceries or clothes without help?	☐	☐
8. Can you prepare your own meals?	☐	☐
9. Can you do your own housework without help?	☐	☐
10. Can you handle your own money without help?	☐	☐
11. Do you need help eating, bathing, dressing, or getting around your home?	☐	☐

12. During the past 4 weeks, how would you rate your health in general?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

13. How have things been going for you during the past 4 weeks?
   - ☐ Very well - could hardly be better
   - ☐ Pretty good
   - ☐ Good and bad parts about equal
   - ☐ Pretty bad
   - ☐ Very bad - could hardly be worse

14. Are you having difficulties driving your car?
- ☐ Yes, often
- ☐ Sometimes
- ☐ No
- ☐ Not applicable, I do not use a car

15. Do you always fasten your seat belt when you are in a car?
☐ Yes, usually ☐ Yes, sometimes ☐ No

16. How often during the past 4 weeks have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up	☐	☐	☐	☐	☐
Sexual problems	☐	☐	☐	☐	☐
Trouble eating well	☐	☐	☐	☐	☐
Teeth or dentures	☐	☐	☐	☐	☐
Problems using the telephone	☐	☐	☐	☐	☐
Tired or fatigued	☐	☐	☐	☐	☐

17. Have you fallen 2 or more times in the past year?
☐ Yes ☐ No

18. Are you afraid of falling?
☐ Yes ☐ No

19. Are you a smoker?
- ☐ No
- ☐ Yes, and I might quit
- ☐ Yes, but I'm not ready to quit

20. During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have?
- ☐ 10 or more per week
- ☐ 6-9 per week
- ☐ 2-5 per week
- ☐ 1 drink or less per week
- ☐ No alcohol at all

21. Do you exercise for about 20 minutes 3 or more days a week?
- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ No, I usually do not exercise this much.

22. Have you been given any information to help you with the following:
- Hazards in your house that might hurt you?
  ☐ Yes ☐ No
- Keeping track of your medications?
  ☐ Yes ☐ No

23. How often do you have trouble taking medicines the way you have been told to take them?
- ☐ I do not have to take medicine
- ☐ I always take them as prescribed
- ☐ Sometimes I take them as prescribed
- ☐ I seldom take them as prescribed

24. How confident are you that you can control and manage most of your health problems?
- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ I do not have any health problems.

How old are you? ☐ 65-69 ☐ 70-79 ☐ 80 or older

Are you male or female? ☐ Male ☐ Female

What is your race? (check one or more than one)
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaskan Native
- ☐ Hispanic or Latino origin or descent
- ☐ Other