

T, TEMPLATES DOB: 01/01/1980 (43 yo M) Acc No. 8663 DOS: 01/01/2001

Progress Note

Patient: T, TEMPLATES
Account Number: 8663
DOB: 01/01/1980 **Age:** 21 Y **Sex:** Male
Phone: 508-836-2700
Address: 123 Main Street, Anytown, MA-01234

Appointment Provider: Sam Willis, M.D.

Date: 01/01/2001

Subjective:

Chief Complaints:

1. Annual Wellness Visit, Initial.

HPI:

Patient Care Team:

- **No Providers on Record.**

Medicare Annual Visit:

Type of Visit

- *First Annual Wellness Visit (IAWV)*

Language or Communication barrier addressed

- Yes

Health Risk Assessment

DEMOGRAPHICS -

- How old are you? ___
- How would you best describe your ethnicity? ___
- How would you describe your marital status? ___
- How would you describe your employment status? ___
- How many children do you have? *None*

RISK ASSESSMENT -

- Do you currently use tobacco products? *No*
- Have you ever used tobacco products? *No*
- What type of tobacco do you use or have you used? ___
- (If cigarette smoker) How long have you smoked? ___
- (If cigarette smoker) How many cigarettes do you smoke per day? ___
- How many alcoholic beverages (i.e. 1oz hard liquor, one glass of wine, one bottle of beer) do you drink daily, on average? *None*
- Have you ever felt the need to cut down on drinking? *No*
- Have people annoyed you with criticism of your drinking? *No*
- Do you or have you felt guilty for drinking? *No*
- Have you ever felt the need to drink first thing in the morning to steady your nerves or to get rid of a hangover? *No*
- How often do you exercise? *Never*
- How vigorously can you exercise? *Minimally*
- How often do you use seatbelts? *Always*
- In the past month, how often have you had sex? ___
- Do you have any significant difficulties or dysfunction during sex? *No, never*
- How many partners do you have? ___
- How often do you experience pain with sex? *Never*
- How often do you use condoms during sex? *Always*

MENTAL HEALTH ASSESSMENT -

- In the past two weeks, how often have you felt depressed, down or hopeless? *Never*
- In the past month, how often have you felt anxious or stressed? *Never*
- What is your average level of daily stress? *None*
- In the past two weeks, how often have you felt a lack of pleasure or interest in doing things? *Never*
- In the past two weeks, how often have you had difficulty falling asleep or episodes of sleeping too long?

Never

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- In the past two weeks, how often have you had a lack of energy? *Never*
 - In the past two weeks, how often have you had feelings of being better off dead or thoughts of harming yourself? *Never*

- Have you ever attempted to harm yourself? *No*

GENERAL HEALTH/PAIN ASSESSMENT -

- In the past month, how often did you experience pain? *Never*
- In the past month, how much has pain affected your ability to work? *Not at all*
- In the past month, how much has pain affected your ability to walk? *Not at all*
- In the past month, how much has pain affected your relationship with other people? *Not at all*
- On a scale of 1-10, how bad would you rate your average daily pain? *No pain*
- How would you describe the ease with which you can prepare your own food? *Very easy*
- How would you describe the ease with which you can bathe or clean yourself? *Very easy*
- How would you describe the ease with which you can dress yourself? *Very easy*
- How hard is it to use the toilet by yourself? *Not hard at all*
- How would you describe the ease with which you can do your own shopping? *Very easy*
- How would you describe the ease with which you can get around your house? *Very easy*
- How would you describe your ability to pay your bills? *Very good*
- How would you describe your ability to plan your daily and monthly budgets? *Very good*
- How would you describe your ability to do routine housework? *Very good*

HOME SAFETY/ASSISTANCE -

- Do you feel like you are safe in your current home? *Yes*
- How many times have you fallen in your home? *Never*
- How much would you need to change your living circumstances to feel safe? *Not at all*
- Do you feel that living somewhere else would be good for you? *No*
- How much help do you feel you need at home? *None at all*
- How much does your family help with daily or routine chores? *Not at all*

Immunization Status addressed

- *Yes*

Depression Screening

- *PHQ9 done, PHQ2 done*

Vision Screening

- *Not done*

Hearing Screening

- *Not done*

Fall Risk and Home Safety

- *Negative, no falls in the past year, no difficulty walking, or getting out of bed or chair*

Get Up and Go Evaluation *under 20 seconds*

Medication evaluation and reconciliation performed *Yes*

Vision screening recommended *Yes*

Literature offered to the patient *Yes*

Referrals *physical therapy offered for gait balance and mobility evaluation, fall prevention home evaluation offered, DEXA screening offered*

Psychosocial Risks

- *No overt psychosocial risks shown, observed, or mentioned*

Behavioral Risks

- *Patient seems very well adjusted and no behavioral issues noted*

Activities of daily living

- *Not impaired*

Cognitive Screening

- *No overt cognitive deficiency is apparent by direct observation*

Medical History:

Family History:

(AWV) Family history verified no changes since last visit.

Social History:

Tobacco Use:

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Tobacco Use/Smoking
Are you a *nonsmoker*

Objective:

Vitals:

Please obtain (AWV) vitals: Height, Weight, BMI and BP.

Assessment:

Assessment:

1. Encounter for general adult medical examination without abnormal findings - Z00.00 (Primary)

Plan:

Treatment:

Procedure Codes: G0438 ANNUAL WELLNES VST; PERSNL PPS INIT

Preventive Medicine:

YOUR PREVENTIVE WELLNESS PLAN:

BMI, Height, and Weight:

The Recommended Frequency is: *Annually*

Blood Pressure:

The Recommended Frequency is: *Every 2 years, if BP <= 120/80 mm Hg, Annually, if BP >120-139/80-89 mm Hg*

Vision:

The Recommended Frequency is: *Every 3 years up to age 40, Every 2 years aged 40+*

Abdominal Aortic Aneurysm:

The Recommended Frequency is: *Once, between the age range of 65-75 and for those who have smoked 100+ cigarettes in lifetime*

Cholesterol Testing:

The Recommended Frequency is: *Regularly beginning at age 20 with risk factors*

Diabetes Screening:

The Recommended Frequency is: *With a sustained BP >= 135/80 mm Hg*

Colorectal Cancer Screening:

The Recommended Frequency is: *Annually, Fecal Occult Blood Stool (FOBS), Every 5 years, Sigmoidoscopy with FOBS, Every 10 years, Colonoscopy*

Prostate Cancer Screening (Digital Rectal Exam [DRE]/Prostate Specific Antigen [PSA]):

The Recommended Frequency is: *Annually, age 50 or older*

Sexually Transmitted Diseases (STDs):

The Recommended Frequency is: *As necessary for those with risk factors*

Depression Screening:

The Recommended Frequency is: *As necessary for those with risk factors*

Alcohol Misuse Screening:

The Recommended Frequency is: *As necessary for those with risk factors*

Pneumococcal (Pneumonia) Vaccine:

The Recommended Frequency is: *1-2 doses up to age 64, 1 dose age 65+*

Influenza (Flu) Vaccine:

The Recommended Frequency is: *Annually*

Other: _____.

Major Risk Factors:

Your Major Risk Factors Include: *Diabetes, Fall risk, Hypertension, Obesity, Smoking use, Other*
Recommendations For Improvement


The recommendations are: *Diet, Exercise, Tobacco cessation, Weight management, Other*

Additional Resources Included: *Follow-up instructions, Handouts, Referrals.*

This plan was discussed, printed, and handed to the patient.

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Images:

A handwritten signature in black ink, appearing to read 'S. Willis', with a long horizontal stroke extending to the right.

Electronically signed by Sam Willis , MD on 10/06/2023 at 11:21 AM EDT
Sign off status: Pending

Appointment Provider: Sam Willis, M.D.

Date: 01/01/2001