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, Subsequent.

HPI:

Patient Care Team:
- No Providers on Record.

Medicare Annual Visit:

Type of Visit
- *Subsequent Annual Wellness Visit*

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
- *No*

Vision Screening
- *No*

Hearing Screening
- *No*

Fall Risk and Home Safety
- *Negative, no falls in the past year, no difficulty walking, or getting out of bed or chair*

Medication evaluation and reconcilliation 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 evauation offered, DEXA screening offered*
Get Up and Go Evaluation *under 20 seconds*

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

Behavioral Risks
- *Patient seems very well adjusted and no behavorial 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:

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

Plan:

Treatment:
Procedure Codes: G0439 ANNUAL WELLNESS VST; PPS SUBSQT VST

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 patient.

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Images:

Electronically signed by Sam Willis , MD on 10/06/2023 at 11:22 AM EDT
Sign off status: Pending

Appointment Provider: Sam Willis, M.D. **Date: 01/01/2001**