INSTRUCTIONS FOR PHYSICAL EXAM

Please bring with you the day of your appointment:

1. Completed demographic, needs to be update yearly, annual screening questionnaires, and Notice of Privacy and Consents acknowledgement.
2. Updated medication list. If you have questions about what you take, please bring all medication bottles with you to your appointment.
3. Stool test, if ordered, and provided in this packet. **(Return to our office)**
4. Copy of your living will, health care POA, and DNR, if applicable and not already shared previously.

On the day of your appointment:

You may have an EKG: Avoid using lotions on your skin to ensure proper contact of the electrodes. (If you see a cardiologist, or have had a normal EKG in the past, this may not be needed.)

Women: If you are due for a pap smear, DO NOT douche for 48 hours prior to your appointment.

Urinalysis: We will perform this in the office if needed. If diabetic, you may have a urinalysis at the lab and the office.

Fasting labs: Using the order provided, please complete the FASTING labs between 1 month and 1 week prior to your appointment.

Your appointment is scheduled for:

DAY:______________________________ DATE:_________________________

ARRIVAL TIME:______________________ APPOINTMENT TIME:________________

3221 N WINDSONG DR PRESCOTT VALLEY, AZ 86314 - PHONE 928-910-7010 - FAX 928-910-7011

If you need to reschedule, we ask that you notify us 24 hours in advance.

We ask that you check in 30 minutes prior to your

appointment time for clinical preparation.

Services that may be rendered during your Physical Exam and Annual Wellness Visit.

For Medicare patients:

1. Office visit – treatment of chronic or acute conditions, and possible head to toe exam. Codes that you **may** see: 99212, 99213, 99214, and 99215. Provider determines code based on treatment. These codes are subject to deductible and co-insurance responsibilities.
2. Medicare Welcome to Medicare or Annual Wellness Visit. Codes that you **may** see: G0402, G0438, G0439, 99397, G0403, G0442, and G0444 – these codes are covered completely by Medicare and cover only preventive portion of your physical. This exam is limited to basic vitals, review of health risks, update to your medical history and family history, update to your medical provider list, cognitive assessment, depression and alcohol use screening, review of functional status, update preventive service schedule, review of risk factors, and action required based on any findings.
3. 93000 for EKG, G0328 for stool card, and 81002 for urinalysis.
4. 99497 for living will discussion, if performed.

For Commercial patients:

1. Office visit – treatment of multiple extensive chronic or acute conditions. Codes that you **may** see: 99212, 99213, 99214, and 99215. Provider determines code based on treatment. These codes are subject to deductible and co-insurance responsibilities.
2. Annual Physical codes that you **may** see: 99395, 99396, 99397 (based on age). 93000 – EKG, 82274 – stool card, 81002 – urinalysis in office. 99408, 99420, & 99497 – Alcohol & Depression screening, and Living Will Discussion.

IF YOU DON'T DRINK ALCOHOL CHECK HERE____SKIP TO PHQ-9

Alcohol Use Questionnaire

When talking with others, do you ever underestimate how much you drink?	Yes	No
After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?		
Does having a few drinks help decrease your shakiness or tremors?		
Does alcohol sometimes make it hard for you to remember parts of the day?		
Do you usually take a drink to relax or calm your nerves?		
Do you drink to take your mind off your problems?		
Have you ever increased your drinking after experiencing a loss in your life?		
Has a doctor or nurse ever said they were worried or concerned about your drinking?		
Have you ever made rules to manage your drinking?		
When you feel lonely, does having a drink help?		

Total Score____________

If you answered **"yes"** to two of the above questions, **please complete the audit questionnaire below.**

	How often do you have a drink containing alcohol?		How many standard drinks containing alcohol do you have on a typical day?		How often do you have six or more drinks on one occasion?
	Never (0 points)		None, I don't drink (0 points)		Never (0 points)
	Monthly or less (1 point)		1 or 2 (0 points)		Less than monthly (1 point)
	2-4 times a month (2 points)		3 or 4 (1 point)		Monthly (2 points)
	2-3 times a week (3 points)		5 or 6 (2 points)		Weekly (3 points)
	Four or more times a week (4 points)		7 to 9 (3 points)		Daily or almost daily (4 points)
			10 or more (4 points)		

Total Score ____________

In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive.

PHQ-9

Low Mood	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things.				
2. Feeling down, depressed, or hopeless.				
3. Trouble falling/staying asleep, sleeping too much				
4. Feeling tired or having little energy				
5. Feeling bad about yourself; that you are a failure or have let your family down				
6. Poor appetite or overeating				
7. Trouble concentrating on things, such as reading the newspaper or watching television				

NAME:________________________________DOB:______________DATE::________________

Low Mood	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety/restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				
Total Score:				

0-4 Normal   5-9 Mild   10-14 Moderate   15-19 Moderate to Severe   20-27 Severe

GAD-7

Low Mood	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				
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
Total Score:				

>/= 10 Probably diagnosis of GAD further examination needed - **5** Mild anxiety - **10** Moderate anxiety - **15** Severe Anxiety

Activities of Daily Living (ADL)

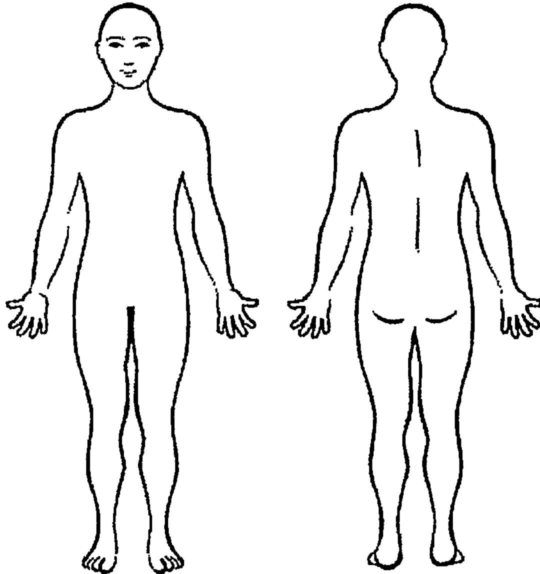
ADL Function	Independent	Needs Help	Dependent	Cannot Do
Bathing				
Grooming				
Mouth Care				
Toileting				
Transferring Bed/Chair				
Walking				
Climbing stairs				
Eating				
Shopping				
Cooking				
Managing medications				
Using the phone and looking up numbers				
Doing housework				
Driving or using public transportation				
Managing finances				

NAME:________________________ **DOB:**____________ **DATE::**____________

WINDSONG PRIMARY CARE

Pain Assessment

Do you have pain? Yes ______No_______ If your answer is No, then please disregard the rest of this questionnaire. If yes, please mark on the diagram where you feel pain.



1. Circle the number that best describes your pain at the **worst** in the past 24 hours.
   0 1 2 3 4 5 6 7 8 9 10
   No Pain — Pain as bad as you can imagine

2. Circle the number that describes your pain at it's **least** in the past 24 hours.
   0 1 2 3 4 5 6 7 8 9 10
   No Pain — Pain as bad as you can imagine

3. Circle the number that is your pain on **average.**
   0 1 2 3 4 5 6 7 8 9 10
   No Pain — Pain as bad as you can imagine

5. Circle the number that is your pain **right now.**
   0 1 2 3 4 5 6 7 8 9 10
   No Pain — Pain as bad as you can imagine

6. Circle the number that best describes your pain at **the worst in the past 24 hours.**
   0 1 2 3 4 5 6 7 8 9 10
   No Pain — Pain as bad as you can imagine

NAME:_________________________________**DOB:**______________**DATE::**________________

7. What treatments or medications are you receiving for your pain?

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____
____
____
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8. How much relief have the pain measures given you in the past 24 hours?

0 1 2 3 4 5 6 7 8 9 10

No relief — Complete relief

9. Circle the number that describes how pain has **interfered in your life in the last 24 hours.**

General Activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Mood

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Walking ability

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Normal work – outside the home and housework

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Fall History

Do you currently or have you had in the past any of the following?

Yes	No	
		Falls in the past year?
		Feel unsteady or worry about falling when standing or walking?
		Have you gone to the ER in the past year because of a fall?
		Do you take exercise classes or do any balance exercises?

Medical Conditions

Yes	No	
		Surgery on your back, knees, or feet?
		Pain in your back, knees, or feet?
		Cognitive impairment?
		Incontinence?
		Depression?
		Poor vision?
		Problems with heart rate and/or rhythm?
		An eye exam within the last year?

Medications

Yes	No	
		CNS or psychoactive medications? (sleeping, anxiety, or narcotic pain medications)
		Medications that can cause sedations or confusion?
		Medications that cause hypotension (low blood pressure)?

Additional information:____

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NAME:________________________ **DOB:**____________ **DATE::**____________