WellCare Member Wellness
Comprehensive Assessment Form

Member Last Name _____ DOB (MM/DD/YYYY) _____

Member First Name _____ DOS (MM/DD/YYYY) _____

Member ID _____ Native Language _____ Gender M / F

Rendering Provider _____ NPI _____

Member's PCP _____

Physical Exam: Vital Signs

Height (in) _____ BMI _____ HR _____ SBP _____ Spo2_____

Weight (lbs.) _____ Temp (F°) _____ RR _____ DBP _____

Allergies: ☐ **No known drug allergies** ☐ **No known food allergies**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications: (List all medications including OTCs with dosage and frequency or attach a printed, signed and dated list and check here:

1159F — Medication List ☐ **No Current Medications**

1.	13.
2.	14.
3.	15.
4.	16.
5.	17.
6.	18.
7.	19.
8.	20.
9.	21.
10.	22.
11.	23.
12.	24.

1160F — Medication List Review

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider Credentials: MD, DO, PA, NP

Surgical History ☐ **Reviewed and No Surgeries**

_____ _____ _____

_____ _____ _____

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Member Name: _____

DOB:_____ **DOS:**_____

Previous Procedures and Outcomes:
(Enter the most recent DOS and results for each)

	Date	Results		Date	Results
Colorectal Cancer Screening			Nephropathy Screening		
Colonoscopy			Microalbuminuria		
FIT DNA/ Cologuard			Macroalbuminuria		
FOBT			HbA1C		
Flexible Sigmoidoscopy			Retinal Eye Exam		
Bone Mineral Density Test			Eye Care Provider Name		
Mammogram			Pneumococcal Vaccine		
Pap Smear			Shingles Vaccine		
Influenza Vaccine					

Family History: ☐ **Reviewed and No Relevant History**

	Father	Mother	Children	Siblings	Grandparents
HTN	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High Lipids	☐	☐	☐	☐	☐

	Father	Mother	Children	Siblings	Grandparents
Dementia	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐

Review of Systems:	**Negative**	**Positive/Findings**
General	☐	
HEENT	☐	
Cardiovascular	☐	
Respiratory	☐	
Digestive/GI	☐	
GU	☐	
Lymphatic/Hematologic	☐	
Skin	☐	
Musculoskeletal	☐	
Nervous	☐	
Endocrine	☐	
Emotional/Psychiatric	☐	
Social History	☐ No ☐ Yes	

Member Name: _____

DOB:_____ **DOS:**_____

1170F — Functional Assessment

Cognitive Status:	☐ Excellent ☐ Diminished ☐ Dementia ☐ Alzheimer's ☐ Parkinson ☐ Other:
Ambulatory Status:	☐ Excellent ☐ Good ☐ Fair ☐ Able to Climb Stairs ☐ Walks With Cane ☐ Uses Wheelchair/Scooter ☐ Needs Assistance ☐ Amputation R / L ☐ Prosthetic Devices:
Hearing:	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Deaf ☐ Hearing Aids or Devices:
Vision:	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Uses Glasses ☐ Uses Contacts ☐ Cataract(s) ☐ Glaucoma R / L ☐ Macular Degeneration ☐ DM Retinopathy ☐ Blind
Speech:	☐ Excellent ☐ Good ☐ Fair ☐ Poor
Other Functional Independence:	(Exercise, ability to perform job, etc.):
Smell / Taste:	☐ Normal ☐ Some Changes
Touch:	☐ Intact ☐ Decreased sensitivity (Hot/Cold) ☐ Numbness:

Activities of Daily Living

	I = Independent	A = Assistance Needed	D = Dependent
Grooming	I	A	D
Dressing	I	A	D
Bathing	I	A	D
Eating	I	A	D
Transferring	I	A	D
Use of Toilet	I	A	D
Walking	I	A	D

Advance Care Planning (CPT II 1123F, 1124F, 1157F, 1158F; CPT 99497, 99498)

Advance Care Planning discussed: ☐ Yes ☐ No

Copy of Advance Care in the chart: ☐ Yes ☐ No

Patient has: ☐ Advance Directive ☐ Living Will ☐ Actionable Medical Orders ☐ Surrogate Decision Maker

Pain Assessment:

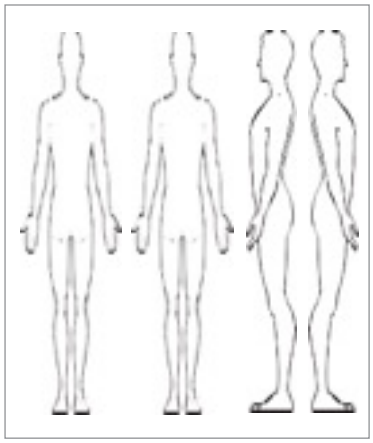
Pain: ☐ No - 1126F ☐ Yes - 1125F Date of Onset:_____

Member Name: _____

DOB:_____ **DOS:**_____

Intensity:

No Pain Mild Moderate Severe Very Severe Worst Pain



Location:_____

Frequency: ☐ Acute ☐ Chronic ☐ Intermittent ☐ Continuous ☐ Occasionally

Type of Pain: ☐ Aching ☐ Crushing ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Radiating
☐ Burning ☐ Tingling ☐ Cramping ☐ Other:_____

Patient/Family Education provided: ☐ Yes ☐ No Psychological Support: ☐ Yes ☐ No Under Pain Management: ☐ Yes ☐ No

If yes to Pain Management, Dr.:_____ Comments: _____

Fall Risk Screening: (Mark all that apply)

Unable to perform exam b/c of:

☐	Diagnoses (3 or more existing)	☐	Polypharmacy (4 or more medications, incl. OTC)
☐	Prior history of falls within 3 months	☐	Pain affecting level of function
☐	Incontinence	☐	Cognitive Impairment
☐	Visual Impairment	☐	Unable to rise from seat w/o U.E.
☐	Impaired functional mobility	☐	Increased Fall Risk (4 or more boxes marked)
☐	Environmental Hazard		

TOTAL number of boxes marked: _____

Depression Screening:

☐ Unable to perform exam because the patient is unable to communicate/answer.
Have you felt depressed or down-and-out over the past 2 months? ☐ Yes ☐ No
Have you had a loss of interest in things that normally bring you pleasure? ☐ Yes ☐ No
Have you felt fatigued or had a loss of energy recently? ☐ Yes ☐ No
If two or more "Yes" then complete and document results from either a: ☐ PHQ9 form ☐ Standard Screening Tool ☐ Clinical Interview
Attach Standard Screening Tool or Clinical Interview to assessment if completed.

Member Name: _____

DOB:_____ **DOS:**_____

Urinary Incontinence Screening:

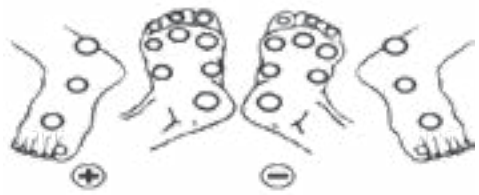
☐ Unable to perform exam because the patient is unable to communicate/answer.
During the last 3 months, have you leaked urine (even a small amount)? ☐ Yes ☐ No
If Yes, please distribute education material.

Physical Exam:

	Normal	Abnormal/Findings		Normal	Abnormal/Findings
General	☐		Rectal	☐	☐ Deferred
HEENT	☐		Pelvis/GU	☐	☐ Deferred
Mouth	☐		Skin	☐	
Neck	☐		Musculoskeletal	☐	
Chest	☐		Pulses	☐	
Heart	☐		Neurologic	☐	
Lungs	☐		Psychiatric	☐	
Breasts	☐		Other	☐	
Abdomen	☐				

Foot Exam (please complete for all patients with Diabetes, Neuropathy, or PAD)

1. Symptoms					
☐ Burning, tingling, numbness in feet		☐ Previous foot ulcer			
☐ Pain or cramping in calf area during exercise		☐ None of these			
2. Inspection					
☐ Infection	☐ Calluses or corns	☐ Nail disorders	☐ Ulceration		
☐ Skin breaks	☐ Foot deformity	☐ None of these			
3. Pulses	Left			Right	
Dorsalis pedis:	☐ Normal	☐ Weak	☐ Absent	☐ Normal	☐ Weak ☐ Absent
Posterior Tibial:	☐ Normal	☐ Weak	☐ Absent	☐ Normal	☐ Weak ☐ Absent
4. Evidence of Neuropathy:	☐ Left Monofilament	☐ Normal	☐ Abnormal	☐ Right Monofilament	☐ Normal ☐ Abnormal
5. Complications Noted (check all that apply):	☐ Ulcer	☐ Gangrene	☐ Peripheral neuropathy	☐ Peripheral vascular disease	☐ None of these



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Member Name: _____

DOB:_____ **DOS:**_____

Treatment Plan: (Document all chronic or acute conditions, and comment on current status.)

Status Key: **AE** = Acute Exacerbation **AC** = Active Controlled **AU** = Active Uncontrolled **ES** = End Stage **RS** = Resolved

No.	Diagnosis	Status	Plan
1.		AE	
2.		AE	
3.		AE	
4.		AE	
5.		AE	
6.		AE	
7.		AE	
8.		AE	
9.		AE	
10.		AE	
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Provider Signature: _____

Provider Printed Name: _____ Provider Credentials: MD, DO, PA, NP