MDX Hawai'i | Annual Health Assessment (AHA) 2024

Member Last Name	First Name	Date of Birth	Gender	Date of Visit

PCP Name	Provider Rendering Today's AHA

Place of Service ☐ **Office** ☐ **Home** ☐ **SNF** ☐ **Other** ____________________ *(Telehealth is Not an Option for (AHA) Annual Health Assessments)*

CC/HPI ☐ Face to Face Visit for Annual Health Assessment ☐ Other ________

ROS (Acute Concerns and Pertinent Positives/Negatives)

Constitutional Symptoms (i.e. Fever, Weight Loss, Vital Signs) ________
Eyes ________ Ears, Nose, Mouth, Throat ________
Cardiovascular ________ Respiratory ________
Gastrointestinal ________ Genitourinary ________
Musculoskeletal ________ Integumentary ________
Neurological ________ Psychiatric ________
Endocrine ________ Hematologic/Lymphatic ________
Allergic/Immunologic ________

MEDICATION LIST (1159F)

☐ Encouraged Patient to Sign Up with Mail Order for Chronic Meds ☐ Converted Chronic Medication Refills to 100 Day Order
☐ Medications Were Reviewed with Patient Today (1160F)
☐ Medications Were Reviewed and Reconciled Today (Within 30 Days Post Discharge) (1111F)

ER VISITS IN LAST 6 MOS?

☐ No ☐ Yes Reason ________
If yes, DOS: ________
☐ Followup within 7 days?
Date of followup ________
Additional DOS:

HOSPITALIZATIONS IN LAST 12 MOS?

☐ No ☐ Yes Reason ________
If yes, DOS: ________
☐ Followup within 30 days? Date: ________
☐ Med Reconciliation done? (1111F)
Additional DOS:

ALLERGIES/INTOLERANCES (Specify Reaction)

COLON CANCER SCREENING (50 - 75y: FOBT Annually, Colonoscopy Every 10 Year)

☐ Exclusion Colorectal CA *or* H/O (☐ Z85.038; ☐ Z85.048)
Type ☐ Colonoscopy ☐ Flex Sigmoid ☐ FIT/FOBT ☐ FIT-DNA/Cologuard
Completed on ________ (date/yr) Result ________
If Not Yet Completed, Scheduled/Ordered on ________ (date/yr)

BREAST CANCER SCREENING (Females 50-74, Every 2 Years) Mammogram G0202/G0204

Exclusion: ☐ Bilateral Mastectomy Z90.13 ; ☐ Rt Z90.11 ; ☐ Lt Z90.12 ; ☐ HX Breast CA (Z85.3)
☐ Date Mammo Completed ________
☐ Scheduled for ________ Facility Name ________

BONE SCAN (Females 67- 85 with FX in last 6 months)

☐ N/A ☐ Doesn't Qualify
☐ 3095F DXA Done Date ________ Result ________
☐ 3096F DXA Ordered Date ________ Location ________
☐ 4005F Name of Osteoporosis Medication Ordered ________

IMAGING ☐ No imaging studies available

	Type of Study	Mo/Yr Study Done
☐ Atherosclerosis of Aorta?		
☐ Atherosclerosis of Extremities?		
☐ Aortic Aneurysm? Size ________cm		
☐ Other Aneurysm? Type ________		

ABI Performed ☐ No ☐ Yes Date ________ Score Right ________ Left ________
PAD ☐ None ☐ Mild ☐ Moderate ☐ Severe

PAST MEDICAL HISTORY

VACCINATIONS

☐ **Covid-19 Vaccine** - Dose #____ Completed on ________
☐ **Flu Vaccine** Completed on ________
☐ **Pneumonia Vaccine** Prevnar 13 Completed on ________
☐ **Pneumonia Vaccine** Preumovax 23 Completed on ________
☐ **Shingles Vaccine** Zostavax Completed on ________

COMMON REOCCURRING CONDITIONS

Patient Has	DX of	HX of	Never had	Family History	Reviewed Med for this DX Today with Patient
Diabetes Type ________ ☐ On Long Term Insulin With Related Comorbidities (List) ________	☐	☐	☐	☐	☐
CKD Stage ________ Related to ________	☐	☐	☐	☐	☐
ESRD ☐ Dialysis Status ☐ AV Fistual/Dialysis Shunt Present Location ________	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
CHF Type ________	☐	☐	☐	☐	☐
CAD ☐ With Angina	☐	☐	☐	☐	☐
Cancer ☐ Active ☐ In Remission ☐ History of Type/Location ________	☐	☐	☐	☐	☐
COPD ☐ With Chronic Respiratory Failure ☐ With Hypoxia ☐ On Oxygen	☐	☐	☐	☐	☐
GERD ☐ With Esophagitis ☐ Without Esophagitis	☐	☐	☐	☐	☐
Hyperlipidemia Type ________	☐	☐	☐	☐	☐
Dementia ☐ With Behavioral Disturbance ☐ Without Behavioral Disturbance	☐	☐	☐	☐	☐
Major Depresssive Disorder ☐ Episode ☐ Single ☐ Recurrent ☐ Mild ☐ Moderate ☐ Severe ☐ With Psychosis ☐ Without Psychosis ☐ Partial Remission ☐ Full Remission	☐	☐	☐	☐	☐
Bipolar	☐	☐	☐	☐	☐
Schizophrenia Type ________	☐	☐	☐	☐	☐
Osteoporosis ☐ Without Fracture ☐ With Current Fracture Fracture Date ____ ☐ Age Related ☐ Other Specify ________	☐	☐	☐	☐	☐
Other ________	☐	☐	☐	☐	☐
Other ________	☐	☐	☐	☐	☐

STATUS CONDITIONS (Check if Present and Restate as Diagnosis on Last Page)

☐ Ostomy Type ________
☐ Transplant Type ________
☐ Amputation ☐ Right ☐ Left Location ________
☐ Late Effects of CVA Describe ________
☐ Right ☐ Left Location ________

Member Last Name	First Name	Date of Birth	Gender	Date of Visit

Patient Health Questionnaire-2 (PHQ-2) (Depression Screening as a "First-Step" Approach.)

Over the last 2 weeks, how often have you been bothered by any of the following?	Not at All	Several Days	More Than Half of the Days	Nearly Every Day	Totals
1. Little interest or pleasure in doing things?	0	1	2	3	
2. Feeling down, depressed, or hopeless?	0	1	2	3	
Note: A PHQ-2 score ranges from 0 to 6; patients with overall scores of 3 or more should be further evaluated with a PHQ-9, other diagnostic instrument(s) or a direct interview to determine whether they meet criteria for a depressive disorder.				**FINAL TOTAL**	

☐ Patient informed that they are being screened to evaluate their mental health as it is equally as important as their physical health

PAIN ASSESSMENT CPT II (Codes 1125F, 1126F) ☐ No Pain, Per Patient, Skip to Next Section

0 to 10 Numeric Pain Rating Scale *(Circle)*

0 1 2 3 4 5 6 7 8 9 10

No pain — Moderate Pain — Worst Possible Pain

Pain Assessment	Score	Clinical Interpertation/DX
☐ Wong-Baker		
☐ Other ____________		

What aggravates pain?____________

What alleviates pain?____________

Location(s) of Pain ____________

Frequency of Pain Over Past 2 Weeks: ☐ Almost All of the Time ☐ Most Times ☐ Sometimes ☐ Almost Never

How is Pain Treated: ☐ Not at all ☐ Medication ☐ Rest ☐ Heat or Cold ☐ Therapy ☐ Other ____________

FUNTIONAL STATUS ASSESSMENT (CPT II Codes 1170F)

Activities of Daily Living	Score	Clinical Interpertation/DX
☐ Patient is independent. All topics dicussed with patient and/or Caregiver		
☐ Katz Index of Independence		
☐ Lawton-Brody Instrumental ADLs (IADLs)		
☐ Other ____________		

Cognitive Screening	Score	Clinical Interpertation/DX
☐ Mini-Cog		
☐ Mini Mental Status Exam (MMSE) (2 Pt = Uncued Words, 1 Pt = Cued Words) **Must Score 4 Pts to Pass**		
☐ Other ____________		

URINARY INCONTINENCE

☐ Patient Informed and asked – Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?

☐ No ☐ Yes ☐ I Don't Know

☐ Treatment Options Offered?

MOBILITY

Which of these assistive devices do you use?

☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Other ☐ None

Do you have trouble with your balance? ☐ No ☐ Yes

Have you fallen in the last six months? ☐ No ☐ Yes

If yes, fall prevention discussed? ☐ No ☐ Yes

Do you have any physical limitations to exercise? ☐ No ☐ Yes

If yes, brief description: ____________

How many minutes do you exercise, **per week**?

☐ <30 Minutes ☐ 30-90 Minutes ☐ 91-120 Minutes ☐ >120 Minutes

SUBSTANCES

☐ **Tobacco** Date/Yr Last Used ____________

☐ Never ☐ Current Use ☐ Former Use ☐ In Remission

☐ Abuse ☐ Dependence

☐ Cigarettes ____Pack Years ☐ Other Type ____________ ☐ Cessation Discussed Today

☐ **Alcohol** Date/Yr Last Used ____________

☐ Never ☐ Current Use ☐ Former Use ☐ In Remission

☐ Abuse ☐ Dependence

How Often ____________ Amount ____________ ☐ Management Options Discussed Today

☐ **Drugs – Benzo/Opiods/ Recreational** Date/Yr Last Used ____________

☐ None ☐ Current Use ☐ Former Use ☐ In Remission

☐ Abuse ☐ Dependence

How Often ____________ Amount ____________ ☐ Management Options Discussed Today

Type(s) ____________

Use: A pattern of psychoactive substance use that is causing damage to health.
Abuse: Continued use of drugs despite adverse effects on their health and well being. Continued to use even though their social life is falling apart or financially collapsing.
Dependence: (Supersedes Abuse)
Physiological need to have the drug
Tolerance – likely to have withdrawal symptoms
Additional criteria as per DSM V

SOCIAL/EMOTIONAL SUPPORT

Which of the following applies to you?

☐ I Have a Supportive Family ☐ I Have Supportive Friends

☐ I Participate in Church, Clubs, or Other Group Activities ☐ Other ☐ None

How often do you get out and meet with family and friends?

☐ Often ☐ Sometimes ☐ Almost Never ☐ Never

HOME COMMUNITY SUPPORT

What is your living situation?

☐ Alone ☐ With My Spouse or Other Family ☐ With a Friend or Roomate

☐ In a Nursing Home or Assisted Living Facility Home ☐ I Don't Have a Place to Live ☐ Other

END OF LIFE PLANNING (CPT/HCPCs Codes 1124F, 1157F, 1158F, S0357)

Advanced Health Care Planning Discussed with Patient and/or Handout Given to Patient

☐ No ☐ Yes

Healthcare Durable Power of Attorney: Name ____________

Advanced Directive ☐ On File ☐ To be Submitted ☐ Patient Declined

POLST ☐ On File ☐ To be Submitted ☐ Patient Declined

NUTRITION

Are you on a special diet?

☐ Diabetic ☐ Gluten Free ☐ Vegan ☐ Vegetarian ☐ Renal ☐ Heart Healthy

☐ None ☐ Other ____________

How many meals a day do you eat? _____

How many servings of fruits/vegetables do you eat, per day? ____/_____

How many servings of protein do you eat, per day? _____

How many servings of fried or processed foods do you eat, per day? _____

Who prepares your meals? ____________

Who shops for your food? ____________

Annual Health Assessment Report 2024 *(continued)*

Member Last Name	First Name	Date of Birth	Gender	Date of Visit

PHYSICAL EAM

Vital Signs

☐ BP Measured (2000F) BP ________/________ ☐ Member self-reported

(If >140/90, please retake Blood Pressure and report Lowest Diastolic and Lowest Systolic for **This Visit**)

Please Check the Appropriate BP Codes

Systolic ☐ SBP < 130 (3074F) ☐ SBP 130-139 (3075F) ☐ SBP 140 or Over (3077F)

Diastolic ☐ DBP < 80 (3078F) ☐ DBP 80-89 (3079F) ☐ DBP 90 or Over (3080F)

Temp

________ °F P ________ R ________

Pulse Ox

________% on RA or ________% on Oxygen ________LPM

Wt ________lbs **Ht** ________ft. ____/____in. **BMI** ________ (3008F) +Z Code

☐ BMI < 20 (Z68.1) ☐ BMI 20-29.9 (Z68.2__) ☐ BMI 30-34.9 (Z68.3__)

☐ BMI 35-39.9 (Z68.3__) ☐ W/Documented/Related Comorbidity*– List ______________

☐ BMI 40-69.9* (Z68.4__) ☐ BMI 70+* (Z68.45)

☐ *Severe Obesity – BMI >40 ***OR*** BMI >35 W/Documented/Related Comorbidity

☐ Unintentional Weight Loss >5% Over 3 Months; or >10% Over 6 Months

General

☐ NAD ☐ In Distress ☐ Cachexia ☐ Temporal Wasting ☐ Other ____________

HEENT

☐ WNL ☐ ABNL ____

Neck

☐ Carotid Bruit ☐ Left ☐ Right

Cardiac

☐ WNL ☐ ABNL ____

☐ AICD: Reason __________________ PPM: Reason __________________

Pulm

☐ WNL ☐ ABNL ____

Abd

☐ WNL ☐ ABNL ____

Ostomy ☐ No ☐ Yes Type/Location ____________________

EXTR Right ☐ 2+ ☐ 1+ ☐ Trace ☐ Not Palpable

VASC Pedal Pulses Left ☐ 2+ ☐ 1+ ☐ Trace ☐ Not Palpable

Skin

☐ No ☐ Yes AV Dialysis Shunt Presence Location ____________________

☐ No ☐ Yes Complication (List) ____________________

☐ No ☐ Yes Ulcer, Nonpressure Description/Location ____________________

☐ No ☐ Yes Ulcer, Pressure Stage - _____ Location ____________________

☐ No ☐ Yes Other (e.g., Senile Purpura, Rash, etc) Describe ____________________

Neuro

Gait ☐ WNL ☐ ABNL____________________

☐ Unsteady ☐ Ataxic ☐ Shuffling ☐ Other __________

Balance Romberg ☐ Positive ☐ Negative ____________________

Related to ____

Motor ☐ WNL ☐ ABNL ____________________

Related to ____

☐ No ☐ Yes Hemiplegia Location ☐ Left Side ☐ Right Side

☐ No ☐ Yes Monoplegia Location ☐ RUE ☐ LUE ☐ RLE ☐ LLE

☐ No ☐ Yes Other ____________________

Related to ____

Sensory

☐ No ☐ Yes ☐ Polyneuropathy *or* ☐ Neuropathy

Based on: ☐ Monofilament test ☐ Vibration Sense ☐ Other: ____________

Related to: ____

Other:

LAB REVIEW

Lab Test	Date of Lab Results	Result
HDL		
LDL		
Triglycerides		
Total Cholesterol		
Platelet Count (K) Thrombocytopenia? ☐ No ☐ Yes		
Intact PTH Hyperparathyroidism? ☐ No ☐ Yes ☐ Secondary to Renal Failure		
Fasting Blood Sugar (List Last 2 Results)		
eGFR (List Last 2 Results) *If patient is diabetic, complete in the section below*		
Urine Albumin-Creatinine Ratio (uACR) (List Last 2 Results) *If patient is diabetic, complete in the section below*		

FOR PATIENTS WITH KNOWN DIABETES ONLY (Required Annually) 18 - 85y

Diabetes ☐ Type 1 ☐ Type 2 ☐ Other ______________________

☐ Diabetes with Hyperglycemia ☐ Controlled Diabetes ☐ Diabetes with Hypoglycemia ☐ Long-Term Insulin

Consider a Statin, if Appropriate (Star Measure)

	If No, please note reason patient is not on medication
On Statin? ☐ No ☐ Yes	
On ACE Inhibitor/ARB? (4010F) ☐ No ☐ Yes	

KED (Kidney Health Evaluation for Patients with Diabetes)

Exclusions ☐ CKD 4 (N18.4) ☐ CKD 5/ESRD (N18.5/N18.6) ☐ Dialysis (Z99.2)

☐ Nephrectomy (50340/50370) ☐ Kidney Transplant (50360/65/80)

Lab Test Required Annually	Date of Lab Results	Result
HbA1c (83036/83037) - **PLUS results** ☐ 3044F HbA1c < 7.0% ☐ 3051F HbA1c 7 – 8% ☐ 3052F HbA1c 8.1 – 9% ☐ > 9%		
☐ **eGFR** (80047/80048/80050/80053/80069/82565) ☐ **AND** uACR or ☐ Quantitative Urine Albumin Test (82043) ☐ **AND** Urine Creatinine (82570)		

Retinal Eye Exam (Annually for Positive Retinopathy; Every Other Year for Negative Retinopathy)

Name of Optometrist/Ophthalmologist & Credential (**Required**) ____________________

____ Exam Date ____________

☐ 2022F Dilated retinal eye exam w/interpretation by an ophthalmologist or optometrist documented and reviewed with evidence of retinopathy

☐ 2023F Dilated retinal eye exam w/interpretation by an ophthalmologist or optometrist documented and reviewed without evidence of retinopathy

☐ 2024F 7 standard field stereoscopic retinal photos w/interpretation by an ophthalmologist or optometrist reviewed and documented with evidence of retinopathy

☐ 2025F 7 standard field stereoscopic retinal photos w/interpretation by an ophthalmologist or optometrist reviewed and documented without evidence of retinopathy

☐ 2026F Eye imaging validated to match dx from 7 standard field stereoscopic retinal photos results documented and reviewed with evidence of retinopathy

☐ 2033F Eye imaging validated to match dx from 7 standard field stereoscopic retinal photos results documented and reviewed without evidence of retinopathy

☐ 3072F Low risk for retinopathy – ***no retinopathy in the prior year (2023)***

☐ 92229 Automated Eye Exam

Exclusions: ☐ Polycystic Ovarian Syndrome; Gestational Diabetes or SIDDM

☐ Unilateral Eye Encleation ☐ Lt (08T1XZZ) ☐ Rt (08T0XZZ) ☐ Bilateral (Mod 50)

☐ Hospice or in a Palliative Care Program

Annual Health Assessment Report 2024 *(continued)*

Member Last Name	First Name	Date of Birth	Gender	Date of Visit

Please add all conditions that coexist, as noted on all prior AHA pages today, and require or affect patient care, treatment, or management, including applicable diagnoses, status and plan for each below.

ICD-10	Specific Diagnosis	Monitor & Evaluation
DX Assessment (Check One)	☐ New ☐ Stable ☐ Worsening ☐ Improving ☐ Other – Describe:	Treatment Plan
ICD-10	Specific Diagnosis	Monitor & Evaluation
DX Assessment (Check One)	☐ New ☐ Stable ☐ Worsening ☐ Improving ☐ Other – Describe:	Treatment Plan
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ICD-10	Specific Diagnosis	Monitor & Evaluation
DX Assessment (Check One)	☐ New ☐ Stable ☐ Worsening ☐ Improving ☐ Other – Describe:	Treatment Plan

Provider's Signature ________________________________ Degree ☐ MD ☐ DO ☐ NP ☐ PA

Print Provider's Name ________________________________ Date ______________