

**McLaren Print System Order**

Order No: 79209 Reprint Previous Order No: 5303  
 Order Date: 2023-09-06  
 User: Tonya Furtah  
 Phone: 8105618450

Ship Location: MMG-St. Clair Family Practice - Attn: Tonya  
 1163 St. Carney Drive  
 St. Clair, MI 48079

**Forms**

Quantity: 500  
 Paragon Dept No: 66000  
 Dept Name: MMG-St. Clair Family Practice  
 Company Number: 810

Order Total Price: 83.80

Item Number: MM-56  
 Item Description: Medicare Annual Wellness Visit  
 Revision Date: 08/2013  
 Print: 2 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish: Staple (Upper Left)  
 Drill: None  
 Misc Info:

McLaren Medical Group  
**Medicare Annual Wellness Visit**

Patient's name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Part B eligibility date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Allergies: \_\_\_\_\_

**Medical and social history**

Past personal illnesses, injuries, operations	Date	Hospitalized?

Tobacco use: \_\_\_\_\_  
 Alcohol use: \_\_\_\_\_  
 Drug use: \_\_\_\_\_  
 Medications, supplements, vitamins: \_\_\_\_\_

**Current list of patient's providers and suppliers**

Name	Specialty	Reason

Height: \_\_\_\_\_  
 Weight: \_\_\_\_\_  
 BMI: \_\_\_\_\_  
 BP: \_\_\_\_\_  
 Visual acuity L: \_\_\_\_\_ R: \_\_\_\_\_

**Family history (check those that apply)**

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia, Sickle Cell	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Obesity	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis

Notes: \_\_\_\_\_

Is the patient on a special diet? Why? \_\_\_\_\_

Detection of cognitive impairment: \_\_\_\_\_

**Depression screen (ask the following questions, check the response)**

1. Over the last few weeks, have you felt down, depressed or hopeless? Yes  No

2. Over the last few weeks, have you lost little interest or pleasure in doing things? Yes  No

**Hearing loss screen**

1. Do you have trouble hearing the television or radio when others do not? Yes  No

2. Do you have to strain or struggle to hear/understand conversations? Yes  No

4400-010  
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 Wellness Visit, Family Practice/Internal Medicine Documentation Template  
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