Patient Name: ______________________________________ Date of Birth: ___________

BCBSIL Subscriber ID: ________________ Name of Physician: ________________________

BlueCross BlueShield of Illinois

# Blue Precision HMO
# Annual Health Assessment Form - Adult

Reason(s) for Visit: Date of Service: ______________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Medications:**

| Name of Medication | Dosage | Frequency | Comments |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |
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| | | | |
| | | | |

**Allergies:**

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Patient Name:** ________________________________________ **Date of Birth:** ____________

## Social History

Language Preference: ☐English ☐ Spanish ☐ Polish ☐ __________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Lives: ☐ Alone ☐ Spouse ☐ Family

Occupation: ____________________________________________________________________

Tobacco Use: ☐ Yes ☐ No Alcohol Use ☐ Yes ☐ No Drug Use ☐ Yes ☐ No

Exercise: ☐ Yes ☐ No Advance Directive: ☐ Completed ☐ Discussed

## Past Medical History:

| | |
|---|---|
| ☐ Asthma | ☐ Other Diagnoses (Please Specify) |
| ☐ Cancer/ Malignancy | ______________________________ |
| ☐ Congestive Heart Failure | ______________________________ |
| ☐ COPD/Emphysema/Chronic Bronchitis | ______________________________ |
| ☐ Coronary Artery Disease | ______________________________ |
| ☐ Depression | ______________________________ |
| ☐ Diabetes | ______________________________ |
| ☐ Hypertension | ______________________________ |

## Surgical History:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

## Family History (Check All That Apply)

| | Mother | Father | Sibling | Grandparent |
|---|---|---|---|---|
| Deceased | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ |
| Liver Disease | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ |
| Other ____________________ | ☐ | ☐ | ☐ | ☐ |
| Other ____________________ | ☐ | ☐ | ☐ | ☐ |

**Patient Name:** ________________________________________ **Date of Birth:** ____________

## Review of Systems

Comments *(If abnormal, explain)*

General (Change in Weight, Fever, Fatigue) ☐ WNL ☐ ABNL ____________________
Skin (Rash, Itching, Hives, Easy Bruising) ☐ WNL ☐ ABNL ____________________
Head (Dizziness, Headaches, Injury) ☐ WNL ☐ ABNL ____________________
Eyes (Vision Change, Pain, Redness, Blindness) ☐ WNL ☐ ABNL ____________________
Ears (Tinnitus, Discharge, Pain, Hearing loss) ☐ WNL ☐ ABNL ____________________
Nose (Nosebleeds, Discharge, Obstruction) ☐ WNL ☐ ABNL ____________________
Mouth/Throat (Lesions, Hoarseness, Pain) ☐ WNL ☐ ABNL ____________________
Neck (Lumps, Goiter, Pain/Tenderness) ☐ WNL ☐ ABNL ____________________
Chest (Cough, Pain, Sputum) ☐ WNL ☐ ABNL ____________________
Breasts (Lumps, Discharge, Pain) ☐ WNL ☐ ABNL ____________________
CV (Chest Pain, HTN, Palpitations) ☐ WNL ☐ ABNL ____________________
GI (Bowel Change, Pain, Rectal Bleeding) ☐ WNL ☐ ABNL ____________________
GU (Incontinence, Blood in Urine, Pain) ☐ WNL ☐ ABNL ____________________
Gyne (Pain, Spotting, Birth Control) ☐ WNL ☐ ABNL ____________________
Vascular (Pain While Walking, Swelling, Ulcers) ☐ WNL ☐ ABNL ____________________
Musculoskeletal (Weakness, Stiffness, Pain) ☐ WNL ☐ ABNL ____________________
Neuro (Numbness, Dizziness, Tremors) ☐ WNL ☐ ABNL ____________________
Psych (Depression, Anxiety, Danger to Self/Others) ☐ WNL ☐ ABNL ____________________

## Physical Exam

Height _______ Weight _______ BMI _______ Temp _______ Pulse ______ Resp ______ BP ________

LMP __________________

Comments (If abnormal, explain)

General ☐ WNL ☐ ABNL ____________________
Head ☐ WNL ☐ ABNL ____________________
Eyes ☐ WNL ☐ ABNL ____________________
ENT ☐ WNL ☐ ABNL ____________________
Neck ☐ WNL ☐ ABNL ____________________
Lungs ☐ WNL ☐ ABNL ____________________
Breasts ☐ WNL ☐ ABNL ____________________
Heart ☐ WNL ☐ ABNL ____________________
ABD ☐ WNL ☐ ABNL ____________________
GU/Gyne ☐ WNL ☐ ABNL ____________________
Gyne ☐ WNL ☐ ABNL ____________________
Rectal r ☐ WNL ☐ ABNL ____________________
Extremities ☐ WNL ☐ ABNL ____________________
MSK ☐ WNL ☐ ABNL ____________________
Neuro ☐ WNL ☐ ABNL ____________________

## Preventive Care

Immunizations:

| Vaccinations | Recommendation | Date of Last Immunization | Due for Vaccination? |
|---|---|---|---|
| Influenza | Annually | | Yes No NA |
| Pneumococcal | One dose age 65 and older, younger if high risk | | Yes No NA |
| Td/Tdap | Tdap once then every 10 years | | Yes No NA |
| HPV | Females 11-26: 3 doses<br>Males 11-21: 3 doses | | Yes No NA |
| Zoster (Shingles) | 60 and older: one dose | | Yes No NA |
| Varicella | 2 doses if not immune | | Yes No NA |
| MMR | 1-2 doses if born after 1956 and not immune | | Yes No NA |
| | | | Yes No NA |
| | | | Yes No NA |
| | | | Yes No NA |

**Patient Name:** ________________________________________ **Date of Birth:** ____________

Recommended Screenings for Adults:

| Health Factor | Recommendation | Date of Last Screening | Service Due? |
|---|---|---|---|
| Breast Cancer Screening | Every 2 yrs age 50-74 | | Yes No NA |
| Cervical Cancer Screening | Pap every 3 yrs age 21-65, OR Pap + HPV every 5 yrs age 30-65 | | Yes No NA |
| Colorectal Cancer Screening | FOBT annually, OR Flex Sig every 5 yrs OR Colonoscopy every 10 yrs | | Yes No NA |
| Depression Screening | Screen all adults | | Yes No NA |
| Obesity Screening | Screen all adults | | Yes No NA |
| Tobacco Use Screening and Smoking Cessation Advice for Smokers | For smokers, provide smoking cessation advice at each visit | | Yes No NA |
| Alcohol Misuse Screening | Screen all adults | | Yes No NA |

Preventive Services for Which Recommendations Vary with Risk

| Health Factor | Recommendation | Date of Last Screening | Service Due? |
|---|---|---|---|
| Chlamydia Screening | Screen all sexually active women 24 and younger annually or at first OB visit. Screen older women at increased risk annually or at first OB visit | | Yes No NA |
| Cholesterol Screening | Recommended screening varies with age, risk and gender | | Yes No NA |
| Diabetes Screening | Screen if history of high blood pressure or other risk factors | | Yes No NA |
| Osteoporosis Screening | Females ≥65 years of age or at risk | | Yes No NA |
| Gonorrhea Screening | Screen if high risk | | Yes No NA |
| HIV Screening | For all adults age 18-65, older adults at increased risk | | Yes No NA |
| Syphilis Screening | Screen if pregnant or high risk | | Yes No NA |
| Hepatitis C Screening | Screen those at high risk plus screen one time for adults born 1945-1965 | | Yes No NA |
| Abdominal Aortic Aneurysm | Screening once if age 65-75 and ever smoked | | Yes No NA |
| Tuberculosis | Screen if high risk | | Yes No NA |

Counseling/Other Preventive Services

| Health Factor | Recommendation | Date Service Provided | Service Due? |
|---|---|---|---|
| Health Counseling | Counsel re: Tobacco, alcohol, weight, diet, activity, STI prevention and/or endometrial cancer | | Yes No NA |
| Prevention of Falls | Exercise or PT and Vit D for those ≥65 years at increased risk for falls | | Yes No NA |
| Intimate Partner Violence Screening | Screen all adults | | Yes No NA |

**Patient Name:** ____________________________________________ **Date of Birth:** _____________

**Diagnoses/Treatment Plan**

List all Diagnoses and Associated Treatment Plans (Medications, Diagnostic Tests, Referrals, Education, etc.)

Physician Signature_______________________________________________Date____________________

Physician Name_________________________________________________________________________