ACHARYA & SHARMA
MEDICAL CORPORATION

SHASHI B. ACHARYA, M.D., F.A.C.P.
Diplomate, American Board of Internal Medicine & Geriatrics
PRAVIN V. SHARMA, M.D.
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"STAYING HEALTHY " ASSESSMENT
ADULTS, 18 YEARS OF AGE AND OLDER

Patient's name (first, last) _____ Date of birth _____

Sex ❑ Male ❑ Female Today's date _____

You and you health care team can work together better health. Please answer these questions as best you can. You may check (✓) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your medical record.

Do You:

1. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, chiropractor, or other healer)?	❑ Yes	❑ No	❑ Skip
2. See the dentist at least once a year?	❑ Yes	❑ No	❑ Skip
3. Drink milk or eat yogurt or cheese at least 3 times each day?	❑ Yes	❑ No	❑ Skip
4. Eat fruits and vegetables every day?	❑ Yes	❑ No	❑ Skip
5. Try to limit the amount or fried or fast foods that you eat?	❑ Yes	❑ No	❑ Skip
6. Exercise or do moderate physical activity such as walking or gardening 5 days a week	❑ Yes	❑ No	❑ Skip
7. Think you need to lose or gain weight?	❑ Yes	❑ No	❑ Skip
8. Often feel sad, down, or hopeless?	❑ Yes	❑ No	❑ Skip
9. Have friends or family members that smoke in your home?	❑ Yes	❑ No	❑ Skip
10. Often spend time outdoors without sunscreen or other protection such as hat or shirt?	❑ Yes	❑ No	❑ Skip
11. Use any recreational drugs like marijuana, cocaine, speed or other street drugs	❑ Yes	❑ No	❑ Skip

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Name: _____ DOB: _____

Your answers to questions about alcohol and drug use cannot be released to others without your special written permission.

Do You:

12. Use any drugs or medicines to go to sleep, relax clam down, feel better, or lose weight?	☐ Yes	☐ No	☐ Skip
13. Often have more than 2 drinks containing alcohol in one day?	☐ Yes	☐ No	☐ Skip
14. Think you or your partner could be pregnant?	☐ Yes	☐ No	☐ Skip
15. Think you or your partner could have a sexually transmitted disease?	☐ Yes	☐ No	☐ Skip

Have You:	☐ Yes	☐ No	☐ Skip
16. Or you partner(s) had sex without using birth control in the last year?	☐ Yes	☐ No	☐ Skip
17. Or your partner(s) had sex with other people in the past year?	☐ Yes	☐ No	☐ Skip
18. Or you partner(s) had sex without a condom in the past year?	☐ Yes	☐ No	☐ Skip
19. Ever been forced or pressured to have sex?	☐ Yes	☐ No	☐ Skip
20. Ever been hit, slapped, kicked, or physically hurt by someone?	☐ Yes	☐ No	☐ Skip
21. Do you have other questions or concerns about your health	☐ Yes	☐ No	☐ Skip

(Please identify) _____

_____

_____

_____

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Date: _____ Name: _____

IMPORTANT INFORMATION ABOUT YOUR PHYSICAL/MEDICAL EXAM

Dear Patient: (Established & New patients).

Please note that your physical exam consists to two parts:

This pertains to your MEDICAL exam and is billed under the 99205 (new patients) & 99215 (established patients).

This part consists of detailed history taking to address all your medical problems, medications and a detail review of all systems to diagnose and format an appropriate treatment plan. This often requires ordering appropriate blood tests and diagnostic procedures to come to a conclusion and then treat you accordingly. This code and the tests ordered is often subjected to your MEDICAL DEDUCTIBLE which becomes your responsibility. (It is your responsibility to check with your Insurance plan).

The second part consists of your Preventive exam which is often performed on a separate visit. This part is billed with 99395/ 99396/ 99397 code depending on your age bracket for established patients or 99385/ 99386/ 99387 for new patients. The diagnosis code used for this exam is V70.0 which stands for the preventive exam. This part purely addresses all the appropriate preventive measures and addresses your vaccine needs/ colonoscopy/ your evaluations of social and mental health questionnaire, fall prevention details, dietary counseling etc to mention a few.

Please note that this part DOES NOT address the diagnosis and treatment of your ongoing or any new medical complaints or problems. This is generally covered by most insurance plans once a year and also covered by MEDICARE once every 13 months. (Also please check with your insurance about your coverage).

I hope you do understand that we as Board certified Internists aim to address & meet ALL your medical needs for your continued well being in the years to come.

Pravin V Sharma MD

Shashi B Acharya MD

Patient Signature _____

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ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

Name: _____ Member ID: _____

Medicare/P.P.O may not pay for the item(s) or service(s) that are described below. Medicare/P.P.O may not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare/P.P.O rules are met. The fact that Medicare/P.P.O may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare or P.P.O probably will not pay for:

Items or Services:

Annual Physical exam	:	99215 = $200.00
Preventive medical exam	:	99397 or 99396 or 99395 = $150.00

Because:
Medicare & P.P.O Insurance may not cover the Preventive Care. Medicare & P.P.O Insurance may not cover at this level of service and frequency.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, **you should read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you **(Estimated cost: $150 / $200)**, in case you have to pay for them yourself or through other insurance.

Please choose **one** option by checking **one** box. **Sign** and **Date** your choice

☒ **Option 1. Yes. I want to receive these items or services.**

I understand that Medicare/P.P.O will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare/P.P.O. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare/P.P.O is making their decision. If Medicare/P.P.O does pay, you will refund to me any payments I made to you that are due to me. If Medicare/P.P.O denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare/P.P.O.'s decision.

❑ **Option 2. No. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare/P.P.O. and that I will not be able to appeal your opinion that Medicare/P.P.O. won't pay.

Date _____ **Signature of patient or person acting on patient's behalf** _____

Print Name: _____

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare/P.P.O., your health information on this form may be shared with Medicare/P.P.O. Your health information which Medicare/P.P.O. sees will be kept confidential by Medicare/P.P.O.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

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FALL PREVENTION BALANCE AND DIZZINESS SURVEY

Patient Name: _____ Age: _____ Date: _____

To help determine if you may be headed for a fall or have a balance disorder, take the Balance Self Test below. If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he or she may help determine the cause of your symptoms.

Please read each question and check the box that most describes your answer.	Yes or Often	Some-times	No or Never
1. Do you ever lose your balance or feel dizzy or unsteady?			
2. Have you continued to experience dizziness after an injury or accident?			
3. Do you feel unsteady when you are walking or climbing stairs?			
4. Do you feel dizzy while sitting down or rising from a seated or lying position?			
5. Does walking down the isle of a supermarket or stopping next to moving traffic make you dizzy?			
6. Does moving your head quickly make you dizzy or cause you to feel nauseous?			
7. Are you dizzy or unsteady when you first get up in the morning?			
8. Do you ever fall or feel like you are about to fall for no apparent reason?			
9. Do you use a walker, cane, or any other form of assistance for your mobility?			
10. Have you had a recent loss of, or decrease in, your vision or hearing?			
11. Do you fear falling?			
12. Have you experienced dizziness, vertigo, or serious imbalance in the past six months?			
13. Has your balance problem caused problems in your social life?			
14. Have you fallen more than once in the past year without an obvious cause?			
15. Does dizziness or imbalance interfere with your job or your household responsibilities?			

Please fill out the top with your name and date, sign the survey at the bottom and provide this to your physician during your visit.

Patient Signature _____ Phone _____

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PHQ-9 DEPRESSION SCREENER SCORING TALLY SHEET
PATIENT HEALTH QUESTIONNAIRE

Name: _____ DOB: _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and mark your response.

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless				
Trouble falling asleep, staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or feeling that you are a failure, or feeling that you have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
Thinking that you would be better off dead or that you want to hurt yourself in some way				
TOTALS				

2. If you marked any problem on this questionnaire so far, 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
0	1	2	3

Patient Name _____ Date _____

PHQ-9 scoring for severity determination
For healthcare professional use only

Scoring-add up all checked boxes on PHQ-9

For ever: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3.

Total Score	Depression Serverity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

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SLEEP QUESTIONNAIRE

PATIENT INFORMATION

Patient Name: _____ DOB _____ Gender: ☐ M ☐ F

Pt. Height _____ Pt. Weight: _____ Reffering Physician: _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired or fatigued? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to imagine how they would affect you. Use the following scale to choose the most appropriate number in each situation.

0 = Would Never Doze 1 = Slight Chance of Dozing 2 = Moderate Chance of Dozing 3 = High Chance of Dozing

Sitting and reading	0	1	2	3
Watching T.V.	0	1	2	3
Sitting, inactive in a public place (theatre, meeting, classroom)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down for a rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total Score: _____

Sleep Questionnaire

Do You Snore?	☐ Yes	☐ No	Do you wake up tired?	☐ Yes	☐ No
Do you have trouble falling asleep?	☐ Yes	☐ No	Do awaken from gasping/choking?	☐ Yes	☐ No
Do you have high blood pressure?	☐ Yes	☐ No	Are you depressed?	☐ Yes	☐ No
Do you wake up with a headache?	☐ Yes	☐ No	Do you have night sweats?	☐ Yes	☐ No
Are you tired throughout the day?	☐ Yes	☐ No	Do you have shortness of breath	☐ Yes	☐ No

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PREPARING FOR YOUR DOCTOR'S VISIT

Name: _____ DOB: _____

Fill out the information below to the best of your ability. Share it with your doctor. Be open and honest in answering any questions your doctor may ask you about the changes you've been experiencing.

Has your health, memory or mood changed?

How did it change?

When did you first notice the change?

How often does it happen?

When does it happen? Is it always at a certain time of day?

What do you do when it happens?

What behaviours are the same?

Do you have problems with any of the following?

Please check the answer.

Repeating or asking the same thing over and over?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

Remembering appointments, family occasions, holidays?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

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Name: _____ DOB: _____

Writing checks, paying bills, balancing the checkbook?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

Shopping independently (e.g., for clothing or groceries)?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

Taking medications according to the instructions?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

Getting lost while walking or driving in familiar places?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

Medications and medical history

List medications (dosage, frequency) including over-the-counter and prescription:

_____

_____

List vitamins and herbal supplements:

_____

_____

List current medical conditions:

_____

_____

List past medical conditions:

_____

_____

Questions to ask the doctor

What are the tests I need to take and how long will it take to get a diagnosis?

Will you refer me to a specialist?

Could the medicines I'm taking be causing my symptoms?

Do I have any other conditions that could be causing my symptoms or making them worse?

What should I expect if it is Alzheimer's?

Which treatments are available for Alzheimer's? What are the risks and benefits and possible side effects?

What about participating in a clinical trial? What are the risks and benefits?

Is there anything else I should know?

When should I come back for another visit?

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MAINTAINING A HEALTHY LIFESTYLE

Name: _____ DOB: _____

Our main focus on health is to prevent disease. The following advice will help you stay in good health.

1. Eat healthy food. Increase fiber in your diet by including plenty of fruits and vegetables.
2. Excercise regularly. Excercise physiologists recommend 30 minutes of exercise 7 times a week. Brisk walking, jogging, swimming, cycling, treadmill, or any excercise which gives you pleasure is ok.
3. It has been proven that wearing a seat belt while driving and a helmet when cycling prevents injuries.
4. Using sunscreen when exposed to sun will prevent skin cancers. The higher the number, the greater the protection.
5. Self-examination once a month of breasts for all women, and breasts and testicular examination for all men, is recommended. This will detect tumors, and if found early, may cure cancer.
6. You should be immunized with Tetanus Toxoid every 10 years and Influenza vaccine every year in the fall season. If you are 65 and older or suffer from diabetes, lung diseases, cancer, heart or any chronic illness, Pneumonia vaccine is advised.
7. Protected sex has been proven to prevent sexually transmitted diseases like Chlamydia, Gonorrhea, Syphilis, Aids, Hepatitis and others.
8. A daily dose of 81 mg of aspirin is known to prevent heart attack and stroke. It is available as Ecotrin, Bayer's Coated Aspirin, or as coated generic aspirin.
9. A daily dose of 1000 units of Vitamin E helps improve memory.
10. To prevent Osteoporosis, all women should take calcium with vitamin D every day (1200 mg to 1500 mg of calcium, and 400 units of vitamin D). It is available as Tums, Oscal, and Caltrate etc. The pharmacist may suggest other brands.
11. Cigarette smoking is known to cause cancer, heart disease and stroke. We encourage you to discuss smoking cessation with your doctor.
12. Illicit street drugs are dangerous to health.

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FALL PREVENTION TIPS

Name: _____ DOB: _____

Falls are the leading cause of injury and accidental death in adults over the age of 65 years. New or unfamiliar surroundings, improper footwear, cumbersome furniture arrangements, and distractions all can cause a person to accidentally stumble and fall, causing a serious injury, even death. Grace L. Walker, PT, DPT, OTD, says, "If a patient is unable to stand on one leg for one minute without support, this may bee a good candidate for our balance and fall prevention program." Grace goes on to say, "Implementing a few prevention practices at home can decrease a person's risk of an unnecessary fall."

Grace recommends:

Be sure you have adequate lighting throughout the house.

Wear appropriate footwear. When walking long distances or in unfamiliar areas, wear flat, nonslip shoes that fit well, and are comfortable.

Install railings in hallways and grab bars in the bathroom and shower to prevent slipping.

Arrange furniture so that it creates plenty of room to walk freely. If you are using a walking aid, ensure that doorways and hallways are large enough to get through with any devices you may use.

Install nonslip strips or a rubber mat on the floor of the tub or shower.

Do not walk and talk at the same time. Concentrate on the task of walking and continue the conversation after you've reached a safe place.

Remove throw rugs or secure them firmly to the floor.

Know your limitations. If there is a task you can not complete with ease, do not risk a fall by trying to complete it.

Use caution when carrying items while walking.

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