

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	THIRUMOHAN N
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1985-07-23
Evaluation Date :	
Visit Type :	

Demographics

Name	THIRUMOHAN N
Gender	Male
Address	BANGALORE
City	BANGALORE
State	KA
Zip	123456
Date of Birth	1985-07-23
Age(as of date)	35
Marital Status	
Member Identification Number	102
HICN	A1B2C3D4E5
Phone Number	1234567890
Cell Number	
Email	
Emergency Contact	
Phone Number	
Primary Care Physician	JOHN
Phone Number	123456
PCP Address	BANGALORE
PCP City	BANGALORE
PCP State	KA
PCP Zip	12345
PCP County	HENRY
Office ID	P123456
Office Name	PRIVATE MEDICAL GROUP LLC

1. Race <i>Answer:</i> African American
2. Preferred language <i>Answer:</i> English

Current Conditions / Suspect Codes		
Current Conditions		
Date of Service	Diagnosis Code	Diagnosis
Suspect Codes		
Date of Service	Diagnosis Code	Diagnosis

Covid Screening
<p>In the last 14 days, have you:</p> <p>Traveled internationally? <i>Answer:</i> Yes</p> <p>Had known exposure to anyone diagnosed with Corona virus (COVID-19) <i>Answer:</i> Yes</p> <p>Had close contact with someone who has traveled to a high risk area? <i>Answer:</i> Yes</p> <p>Developed Fever? <i>Answer:</i> Yes</p> <p>Developed Cough? <i>Answer:</i> Yes</p> <p>Developed Flu like symptoms? <i>Answer:</i> Yes</p> <p>Developed Shortness of breath? <i>Answer:</i> Yes</p>

Screenings Needed				
Screening Name	Member Eligible	Screening Completed	Screening Result	Diagnosis
DIGITAL_RETINAL_EXAM	No	Select		
HBA1C	No	Select		

MICROALBUMIN	No	Select		
FOBT	No	Select		
DEXA	No	Select		
PAD	Select	Select		
Peak Flow Meter	Select	Select		
LDL	Select	Select		

Self-Assessment and Social History

3. How much school have you completed?
Answer: Less than 3rd grade

4. When you get written information at a doctor's office would you say it is
Answer: Very difficult

5. When you read the instructions on a prescription bottle would you say that it is
Answer: Very difficult

6. How confident are you in filling out medical forms by yourself?
Answer: Not at All Confident

7. How would you rate your health compared to other persons your age?
Answer: Excellent

8. During past 3 months, has your physical and or emotional health limited your social activities with family, friends, neighbours or groups?
Answer: Often

9. Where do you currently live?
Answer: Home

10. Do you have someone you can rely on to help if you are sick or have problems you need to discuss?
Answer: Yes

11. Who do you currently live with?
Answer: Alone
Describe
Answer:

12. Are you currently a caregiver for someone?
Answer:

13. Tobacco use
Answer: Current
Type

<div>Answer:Cigarettes</div> <div>How Many</div>
<div>14. Alcohol Use</div> <div>Answer: Never</div>
<div>15. Do you or have you used recreational drugs or pain medication?</div> <div>Answer:</div>
<div>16. Do you have a Healthcare Proxy?</div> <div>Answer:</div>
<div>17. Do you have a Durable Power of Attorney?</div> <div>Answer:</div>
<div>18. Do you have an Advance Directive?</div> <div>Answer:</div>

<div>Activities of Daily Living</div>
<div>19. Do you have any difficulty with the following activities?</div> <div><div>A. Getting in or out of bed</div><div>Answer:</div><div>B. Getting in or out of chairs</div><div>Answer:</div><div>C. Toileting</div><div>Answer:</div><div>D. Bathing</div><div>Answer:</div><div>E. Dressing</div><div>Answer:</div><div>F. Eating</div><div>Answer:</div><div>G. Walking</div><div>Answer:</div><div>H. Going up or down stairs</div><div>Answer:</div></div>

<div>Medical History</div>
<div>20. Do you use any assistive devices? (Check device or none if no devices used)</div> <div>Answer: Cane , Walker</div>

Comment: C W
21. Are you currently seeing any specialists?
22. In the past 12 months how many times have you? A. Seen your PCP Answer: B. Visited the Emergency Room Answer: C. Stayed in the hospital overnight Answer: D. Been in a nursing home Answer: E. Had Surgery Answer:
23. Have you ever been hospitalized prior to the last 12 months? Answer:
24. In the past year have you received health services from any of the providers below: Physical Therapist Answer: Occupational Therapist Answer: Dietician Answer: Social Worker Answer: Pharmacist Answer: Speech Therapist Answer: Chiropractor Answer: Personal Care Worker (HHA, CNA, PCA) Answer: Meals on Wheels Answer:

25. In the past two years have you received any of the treatments below?

Chemotherapy

Answer:

Catheter Care

Answer:

Oxygen

Answer:

Wound Care

Answer:

Regular Injections

Answer:

Tube Feedings

Answer:

Family History

26. Family History

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	
Breast Exam/Mammography	
Cervical Screening	
Bone Density	
Prostate Exam/PSA	
If Diabetic Eye Exam	
If Diabetic Foot Exam	
If Diabetic Hgb A1c screen	
Lipid Panel	

28. Last colonoscopy if more than 2 years ago

Answer:

29. Screen for abnormal glucose / diabetes - age 40 - 70

Answer:

30. One time screen for Abdominal Aortic Aneurysm if male with history of smoking, age 65 - 75

Answer:

31. One time screen for Hepatitis C if born between 1945 - 1965

Answer:

32. Do you get Flu Vaccine each year?

Answer:

33. Have you been vaccinated for Pneumonia?

Answer:

34. Have you been vaccinated for Herpes Zoster?

Answer:

Allergies / Medications

35. Allergies

Answer: yes

Substance	Reaction
1	2

Medications

Dose Date	Label Name	Dose / Units	Route	Frequency	Status
	safsf	20mg	PO = By Mouth	AC	Taking

36. Over the Counter Medications / Supplements

Answer: yes

Date	Description	Dose/Units	Route	Frequency
	Des	10	SQ = Subcutaneous	120

37. Chronic Use of

Answer: ASA , Biphosphonate

Comment: A B

38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?

Answer:

2. Do you sometimes not pay enough attention to your medication?

Answer:

3. Do you know the longterm benefit of taking your medicine as told to you by the doctor or pharmacist?

Answer:

4. When you feel better do you sometimes stop taking your medicine?

Answer:

5. Sometimes if you feel worse when you take your medicine do you stop taking it?

Answer:

6. Do you sometimes forget to refill your prescription on time?

Answer:

Review of Systems and Diagnoses

EYES

Eye Problems (Glaucoma, Cataracts, Macular Degeneration, Blindness, Retinal Detachment, Other)

Answer: Yes

Diagnoses

Cataracts

Describe

Answer: Active

Supported by

Answer: History, Symptoms, Physical Findings, Medications, Test results, Image studies, Biopsy, DME, Other

Secondary to Diabetes

Answer:

Difficulty with vision

Describe

Answer:

Legally Blind

Answer:

Glaucoma

Describe

Answer:

Supported by

Answer:

Secondary to Diabetes

Answer:

Macular Degeneration

Describe

Answer:

Supported by

Answer:

Describe

Answer:

Retinal Disease

Describe

Answer:

Supported by

Answer:

Secondary to Diabetes

Answer: Yes

Others

Describe

Answer:

Supported by

Answer:

Other

Answer:

Do you wear glasses or contacts?

Answer: Yes

Do you have trouble seeing even with glasses?

Answer :

Do you have problems seeing at night?

Answer: No

Do you have eye pain?

Answer: No

Do you have problems with tearing?

Answer: No

Do you have a problem with dry eye?

Answer: No

EARS

Ear Problems (Hard of hearing, Deaf, Vertigo, Ear Infections)

Answer: Yes

Diagnoses

Difficulty with Hearing

Describe

Answer:

Do you have trouble hearing when people talk to you?

Answer:

Do you wear a hearing aid?

Answer:

Do you read lips?

Answer:

<div>Do you have ear pain or drainage? Answer:</div> <div>Do you ever get dizzy? Answer:</div>
<div>NOSE</div> <div>Nose Problems (Nose Bleeds, Sinus infections, Other) Answer:</div>
<div>MOUTH AND THROAT</div> <div>Mouth and Throat Problems (Difficulty Chewing, Difficulty Swallowing, Bleeding Gums, Other) Answer: Yes</div> <div>Diagnoses</div>
<div>NECK</div> <div>Neck Problems (parotid Disease, Carotid Stenosis, Other) Answer:</div>
<div>RESPIRATORY</div> <div>Respiratory Problems (COPD, Emphysema, Asthma, Chronic Bronchitis Pneumonia, Other) Answer:</div>
<div>CARDIOVASCULAR</div> <div>Cardiovascular (Hypertension, Angina, Ischemic Heart Disease(CAD), Myocrdial Infarction, Other) Answer:</div>
<div>GASTROINTESTINAL</div> <div>Gastrointestinal Problems (Ulcer, Reflux, Hiatal Hernia, Colitis, Other) Answer:</div>
<div>Bowel Movements Answer:</div>
<div>Abdominal Openings Answer:</div>
<div>Rectal Problems Answer:</div>

Last Bowel Movement

Answer:

NEURO-PSYCH

Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)

Answer:

Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)

Are you nervous, anxious, feel on the edge or often feel stressed?

Answer:

Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)

Do you worry too much about different things?

Answer:

Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)

Do you feel afraid that something bad might happen?

Answer:

Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)

How often do you go out to meet with family or friends

Answer:

GPCOG Score or MMSE Score

GPCOG Score	
or MMSE Score	

If GPCOG or MMSE is not done, is

Patient oriented to person

Answer:

Patient oriented to place

Answer:

Patient oriented to time

Answer:

Recall

Answer:

Patient describes recent news event

Answer:

Affect

<div>Answer:</div> <div>Over the past 2 weeks, how often have you been bothered by any of the following problems?</div> <div>Little interest or pleasure in doing things</div> <div>Answer:</div> <div>Feeling down, depressed or hopeless</div> <div>Answer:</div> <div>PHQ 2 Score : <3</div>
<div>Speech</div> <div>Answer:</div>
<div>Finger to Nose</div> <div>Answer:</div>
<div>Heel (Shin) to Toe</div> <div>Answer:</div>
<div>Thumb to Finger Tips</div> <div>Answer:</div>
<div>Sitting to Standing</div> <div>Answer:</div>
<div>Facial / Extremity Movement</div> <div>Answer:</div>
<div>Gait</div> <div>Answer:</div>
<div>GENITOURINARY</div> <div>Genitourinary Problems (Overactive Bladder, Urinary Incontinence Stress Incontinence,Benign Prastatic Hypertraphy, Others)</div> <div>Answer:</div>
<div>MUSCULOSKELETAL</div> <div>Musculoskeletal Problems (Spinal Stenosis, Rheumatoid Arthritis, Gout, Osteoporosis, Others)</div> <div>Answer:</div>
<div>INTEGUMENT</div> <div>Integument Problems (Eczema, Psoriasis, Dermatitis, Urticaria, Other)</div>

Answer:
ENDOCRINE
Endocrine Problems
Answer:
Have you lost weight in the past 6 months?
Answer:
HEMATOLOGY / IMMUNOLOGY / INFECTIOUS DISEASE
Hematology / Immunology / Infection Disease Problems (Anemia, easy bruising or abnormal bleeding Thrombocytopenia , Other)
Answer:
CANCER
Diagnosis of Cancer
Answer:

Pain
Does the patient experience pain?
Answer: Yes
Is the Pain Acute?
Answer:
Is the Pain Chronic?
Answer:
Is the Patient Undergoing Pain Management Planning?
Answer:
Was the patient advised regarding the potential for dependence?
Answer:
Is there any evidence of Maladaptive Behavior?
Tolerance?
Answer: Yes
Withdrawal?
Answer:
Increased usage over a longer period that intended?
Answer:

Desire or unsuccessful effort to cut down on use?

Answer:

Excess time spent in activities to obtain the substance?

Answer:

Continued use despite Doctor advice or patient knowledge of habituation?

Answer:

Physical or Psychological Problem related to the substance use?

Answer:

Vital Signs

Vital Signs

Blood Pressure	
Pulse	
Respiratory Rate	
Temp	67
Pulse Oximetry	76
Pain Scale /10	

BMI

Comment:

Patients Height	
Patients Weight	
BMI	

Exam Review

Constitutional

General appearance:

Answer:

Head and Face

Examination of head and face:

Answer:

Palpation of the face and sinuses:

Answer:

Eyes

Inspection of conjunctiva and lids: <i>Answer:</i>
Examination of pupils and irises: <i>Answer:</i>

Ears, Nose, Mouth and Throat
External Inspection of ears and nose: <i>Answer:</i>
Otoscopic examination: <i>Answer:</i>
Assessment of hearing: <i>Answer:</i>
Inspection of nasal mucosa, septum and trubينات: <i>Answer:</i>
Inspection of lips, teeth and gums: <i>Answer:</i>
Examination of oropharynx: <i>Answer:</i>

Neck
Examination of neck: <i>Answer:</i>
Examination of thyroid: <i>Answer:</i>

Pulmonary
Assessment of respiratory effort: <i>Answer:</i>
Percussion of chest: <i>Answer:</i>
Palpation of chest: <i>Answer:</i>
Auscultation of lungs: <i>Answer:</i>

Cardiovascular

Palpation of heart: <i>Answer:</i>
Auscultation of heart: <i>Answer:</i>
Carotid Arteries: <i>Answer:</i>
Abdominal Aorta: <i>Answer:</i>
Pedal Pulses: <i>Answer:</i>
Examination of Arterial Pulses: <i>Answer:</i>
Examination of Edema / Varicosities: <i>Answer:</i>

Lymphatic
Palpation of cervical nodes (neck) <i>Answer:</i>
Palpation of preauricular nodes (in front of the ears) <i>Answer:</i>
Palpation of Submandibular nodes (under jaw line/chin) <i>Answer:</i>

Musculoskeletal
Examination of gait and station: <i>Answer:</i>
Inspection/palpation of digits and nails: <i>Answer:</i>
Inspection/palpation of joints, bones and muscles: <i>Answer:</i>
Assessment of range of motion: <i>Answer:</i>
Assessment of stability: <i>Answer:</i>
Assessment of muscle strength/tone: <i>Answer:</i>

Skin
Inspection of skin and subcutaneous tissue: <i>Answer:</i>
Palpation of skin and subcutaneous tissue: <i>Answer:</i>

Neurologic
Indicate specific cranial nerve tested <i>Answer:</i>
Indicate cranial nerve deficits found <i>Answer:</i>
Romberg Test <i>Answer:</i>
Examination of reflexes: <i>Answer:</i>
Examination of sensation: <i>Answer:</i>
Coordination: <i>Answer:</i>

Diabetes
Foot Exam: <i>Answer:</i>

Psychiatric
Description of patient's judgement / insight: <i>Answer:</i>
Orientation of person, place and time: <i>Answer:</i>
Recent and remote memory: <i>Answer:</i>
Mood and affect: <i>Answer:</i>

Mini-Cog

Word List Version	
Person's Answers	
Word Recall	
Clock Draw	
Total Score	

Home Safety & Personal Goals

40. In the past year how many times have you Fallen?

Answer:

41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?

Answer:

b. Do you have electrical cords running across floors, in doorways or under a rugs?

Answer:

c. Do you have no slip mats on the shower floor or bath tub?

Answer:

d. Do have adequate lighting in hallways and on the stairs?

Answer:

e. Do you have handrails on staircases?

Answer:

f. Is your hot water heater set for a maximum of 120 degrees?

Answer:

g. Do you have smoke detectors on each level of the house and in all sleeping a rooms?

Answer:

h. Do you have carbon Monoxide detectors on each level of the house?

Answer:

i. Have used established an escape route in the event of fire?

Answer:

42. Are there things about yourself you wish you could change or improve?

Answer:

43. Is there anything that you could do to improve your quality of life?

Answer:

44. Have you ever physically or felt emotionally abused by someone

Answer:

45. Feeling like harming others or yourself

Answer:

46. Are you afraid of anyone or is anyone hurting you?


Answer:

Active Problem Conditions

ICD 10	ICD-10 Description	DX Assmt	Monitor & Eval	Tx Plan
R36.0	Urethral discharge without blood	Stable	sdgsdgdsgsd	dsgdsgdsgd
S10.0XXA	Contusion of throat, initial encounter	Worsening	dsgdsgsdgd	dsgdsgsgr
I10.	Essential (primary) hypertension	Worsening	rwgfgsdg	sdgdsgdssdg
B20.	Human immunodeficiency virus [HIV] disease	Disagreed w/Dx	ddsgdsg	sdgsdgsd
C10.0	Malignant neoplasm of vallecula	Improving	sdgsdgsdg	dsgdsgds
D20.0	Benign neoplasm of soft tissue of retroperitoneum	Disagreed w/Dx	dsgsdg	sdg

Patient Summary

Assessors Comments	
Member informed of acknowledgment	true
Date/Time of Service/ Evaluation :	
Time exam finished	
Provider Signature	<div><div>shwe</div><div>Digitally signed by test clinicianFE, FNF 2020-09-09 17:47</div></div>

	<div><div><div>shwe</div><div></div><div>Digitally signed by test clinicianFE, FNF 2020-09-09 18:01</div></div></div> <div><div><div>shwe</div><div></div><div>Digitally signed by test clinicianFE, FNF 2020-09-09 18:07</div></div></div>
Addendum	<div><div><div>Add an addendum</div></div><div><div><div>shwe</div><div></div><div>Digitally signed by test clinicianFE, FNF 2020-09-09 18:15</div></div></div></div>