

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	FLORENCE BRAXTON
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1931-03-23
Evaluation Date :	2021-6-9 11:00 AM
Visit Type :	Virtual: Video & Audio Capability

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICARE
LOB	DSNP
Name	FLORENCE BRAXTON
Gender	Female
Address	PO BOX 1115
City	ORANGE
State	VA
Zip	22960-2808
Date of Birth	1931-03-23
Age(as of date)	90
Marital Status	Widowed
Member Identification Number	11000208
HICN	9Y11N94GV06
Phone Number	5403087403
Cell Number	5407483174
Alternate Contact Number	
Email	
Emergency Contact	Donna Carter
Phone Number	540-360-6474
Primary Care Physician	COOLEY, AMY A
Phone Number	5409486871
PCP Address	13198 James Madison Hwy
PCP City	Orange
PCP State	VA

PCP Zip	229602808
PCP County	
Office ID	P9307431
Office Name	ORANGE FAMILY PHYSICIANS

1. Race

- ☐ Caucasian
 ☒ **African American**
☐ Asian
- ☐ Latino
 ☐ Native American
 ☐ Native Hawaiian or other Pacific Islander
- ☐ Alaskan Native
 ☐ Other

Patient's Ethnicity

- ☐ Hispanic
 ☒ **Non-Hispanic**
☐ Other Ethnicity
- ☐ Prefer not to say

2. Preferred language

- ☒ **English**
☐ Other

Previously Documented Conditions

Covid Screening

In the last 14 days, have you:

Traveled internationally?	Yes	No
Had known exposure to anyone diagnosed with Corona virus (COVID-19)	Yes	No
Had close contact with someone who has traveled to a high risk area?	Yes	No
Developed Fever?	Yes	No
Developed Cough?	Yes	No
Developed Flu like symptoms?	Yes	No
Developed Shortness of breath?	Yes	No

Self-Assessment and Social History

3. How much school have you completed?

- ☐ Less than 3rd grade
 ☒ **Completed 3rd grade**
☐ Completed 8th grade
- ☐ Completed 12th grade
 ☐ Attended College

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

- ☐ Very difficult ☐ Somewhat difficult ☒ **Easy**
☐ Very easy to understand

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

- ☐ Very difficult ☐ Somewhat difficult ☒ **Easy**
☐ Very easy to understand

6. How confident are you in filling out medical forms by yourself?

- ☒ **Not at All Confident** ☐ Not Very Confident ☐ Confident
☐ Very Confident

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

- ☐ Excellent ☐ Good ☐ Fair
☒ **Poor**

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

- ☐ Often ☐ Sometimes ☐ Almost Never
☒ **Never**

9. Where do you currently live?

- ☒ **Home** ☐ Apartment ☐ Assisted Living
☐ Nursing Home ☐ Homeless ☐ Other

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

- ☒ **Yes** ☐ No

11. Who do you currently live with?

- ☐ Alone ☐ Spouse ☐ Partner
☐ Relative ☒ **Family** ☐ Friend
☐ Personal Care Worker

12. Are you currently a caregiver for someone?

- ☐ Yes ☒ **No**

13. Tobacco use

- ☐ Current ☒ **Former** ☐ Never
↳ **Type**
☒ **Cigarettes** ☐ Cigars ☐ Chewing Tobacco
☐ Vaping ☐ Other
↳ **How Many**
☐ 1 - 3 a day ☒ **1/2 a pack** ☐ 1 pack
☐ More than 1 pack ☐ Other

14. Alcohol Use

- ☐ Current ☒ **Former** ☐ Never

How many drinks	How Often
4	Week

15. Do you or have you used recreational drugs or pain medication?

☒ Yes ☐ No

↳ Which drugs or medication
tramadol

16. Do you have a Healthcare Proxy?

☐ Yes ☒ No ☐ Don't Know

17. Do you have a Durable Power of Attorney?

☐ Yes ☒ No ☐ Don't Know

18. Do you have an Advance Directive?

☐ Yes ☒ No ☐ Don't Know

Within the past 12 months we worried whether our food would run out before we got money to buy more. Was that _____ for your household?

☐ Often True ☐ Sometimes True ☒ Never True

Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Was that _____ for your household?

☐ Often True ☐ Sometimes True ☒ Never True

Activities of Daily Living

19. Do you have any difficulty with the following activities?

A. Getting in or out of bed	No	Need Some Help	Need Total Help
B. Getting in or out of chairs	No	Need Some Help	Need Total Help
C. Toileting	No	Need Some Help	Need Total Help
D. Bathing	No	Need Some Help	Need Total Help
E. Dressing	No	Need Some Help	Need Total Help
F. Eating	No	Need Some Help	Need Total Help
G. Walking	No	Need Some Help	Need Total Help

↳ How far can you walk

☐ Household only ☐ Less than one block ☐ One block
☐ Two or more blocks ☒ Non-ambulatory

H. Going up or down stairs	No	Need Some Help	Need Total Help
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↳ How many stairs can you climb

☒ None ☐ Three to five ☐ Six to ten
☐ More than ten

Medical History

20. Do you use any assistive devices? (Check device or none if no devices used)

- ☐ None
 ☐ Cane
 ☐ Walker
 ☐ Prosthesis
☒ **Wheel Chair**
☐ Bedside Commode
 ☐ Urinal
☐ Bed Pan
 ☐ Other

21. Are you currently seeing any specialists?

- ☐ Yes
 ☒ **No**

22. In the past 12 months how many times have you?

A. Seen your PCP	None	1	2	3	4	5 or more
B. Visited the Emergency Room	None	1	2	3	4	5 or more

↳ If one or more, describe

UTI

C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
-------------------------------------	------	---	---	---	---	-----------

↳ If one or more, describe

complicated UTI secondary to ecoli

D. Been in a nursing home	None	1	2	3	4	5 or more
E. Had Surgery	None	1	2	3	4	5 or more

23. Have you ever been hospitalized prior to the last 12 months?

- ☒ **Yes**
☐ No

↳ Describe

complicated uti

24. In the past year have you received health services from any of the providers below:

Physical Therapist	Yes	No
Occupational Therapist	Yes	No
Dietician	Yes	No
Social Worker	Yes	No
Pharmacist	Yes	No
Speech Therapist	Yes	No
Chiropractor	Yes	No
Personal Care Worker (HHA, CNA, PCA)	Yes	No

Meals on Wheels	Yes	No
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25. In the past two years have you received any of the treatments below?

Chemotherapy	Yes	No	Unknown
Catheter Care	Yes	No	Unknown
Oxygen	Yes	No	Unknown
Wound Care	Yes	No	Unknown

Comment: Hx sacral wounds-healed

Regular Injections	Yes	No	Unknown
Tube Feedings	Yes	No	Unknown

Family History

26. Family History

☒ Yes

☐ No

Family Member	Medical Condition	Cause of Death
Mother	diabetes	

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	No
Breast Exam/Mammography	No
Cervical Screening	No
Bone Density	No
Prostate Exam/PSA	Not Applicable
If Diabetic Eye Exam	Yes
If Diabetic Foot Exam	Yes
If Diabetic Hgb A1c screen	Yes
Lipid Panel	Yes

28. Last colonoscopy if more than 2 years ago

☐ 3 – 5 years ago

☐ 6 – 10 years ago

☒ > 10 years ago

☐ Never

☐ Don't know

comments

Patient and daughter both educated on importance of preventative screening.

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

☒ Yes

☐ No

☐ NA

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

65 - 75

☐ Yes

☐ No

☒ NA

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

☐ Yes

☐ No

☒ NA

32. Do you get Flu Vaccine each year?

☐ Yes

☒ No

comments

Patient and daughter both educated on importance of preventative screening.

33. Have you been vaccinated for Pneumonia?

☐ Yes

☒ No

comments

Patient and daughter both educated on importance of preventative screening.

34. Have you been vaccinated for Herpes Zoster?

☐ Yes

☒ No

comments

Patient and daughter both educated on importance of preventative screening.

Allergies / Medications

35. Allergies

☒ Yes

☐ No

Substance	Reaction
PCN	hives

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
diabetes	METFORMIN	TAB 500MG	PO = By Mouth	BID	Dr. Marina	Taking	Not Taking
	TRAMADOL HCL	TAB 50MG	Select	Select		Taking	Not Taking
UTI	CIPROFLOX ACN	TAB 500MG	PO = By Mouth	BID	ED physician	Taking	Not Taking
diabetes	GLIPIZIDE ER	TAB 2.5MG	PO = By Mouth	AC	Dr. Marina	Taking	Not Taking
HTN	AMLODIPINE	TAB 10MG	PO = By Mouth	QD	Dr. Marina	Taking	Not Taking
HTN	ATENOLOL	TAB 100MG	PO = By Mouth	QD	Dr. Marina	Taking	Not Taking
DVT	ELIQUIS	TAB 2.5MG	PO = By Mouth	BID	Dr. Marina	Taking	Not Taking
	SMZ/TMP DS	TAB 800-160	Select	Select		Taking	Not Taking
GERD	OMEPRAZOL E	CAP 20MG	PO = By Mouth	QD	Dr. Marina	Taking	Not Taking

HTN	HYDRALAZINE	TAB 25MG	PO = By Mouth	TID	Dr. Marina	Taking	Not Taking
	SANTYL	OIN 250/GM	Select	Select		Taking	Not Taking
HTN	LOSARTAN POT	TAB 100MG	PO = By Mouth	QD	Dr. Marina	Taking	Not Taking
	ONDANSETRON	TAB 4MG ODT	Select	Select		Taking	Not Taking
	PROMETHAZINE	TAB 12.5MG	Select	Select		Taking	Not Taking
	DICLOFENAC	GEL 0.01	Select	Select		Taking	Not Taking
	KETOROLAC	SOL 0.005	Select	Select		Taking	Not Taking
	LISINOPRIL	TAB 40MG	Select	Select		Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ **Yes** ☐ **No**

Date	Description	Dose/Units	Route	Frequency
07-01-2021	tylenol	500mg	PO = By Mouth	PRN

37. Chronic Use of

☐ None
 ☐ ASA
 ☐ Steroids
 ☐ Insulin
☒ **Anticoagulants**
☐ Statins
 ☐ Biphosphonate

38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?	Yes	No
2. Do you sometimes not pay enough attention to your medication?	Yes	No
3. Do you know the longterm benefit of taking your medicine as told to you by the doctor or pharmacist?	Yes	No
4. When you feel better do you sometimes stop taking your medicine?	Yes	No
5. Sometimes if you feel worse when you take your medicine do you stop taking it?	Yes	No
6. Do you sometimes forget to refill your prescription on time?	Yes	No

Review of Systems and Diagnoses

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

☒ **Yes** ☐ **No**

Diagnoses

☒ **Cataracts**
☐ Difficulty with vision
☐ Glaucoma
 ☐ Hyperopia
☐ Macular Degeneration
 ☐ Myopia
☐ Retinal Disease
 ☐ Others

Cataracts

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☒ Symptoms

☒ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Secondary to Diabetes

☒ Yes

☐ No

Do you wear glasses or contacts?

☐ Yes

☒ No

Do you have problems seeing at night?

☐ Yes

☒ No

Do you have eye pain?

☒ Yes

☐ No

Which Eye?

☐ Right

☐ Left

☒ Both

Do you have problems with tearing?

☒ Yes

☐ No

Do you have a problem with dry eye?

☐ Yes

☒ No

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

☒ Yes

☐ No

Diagnoses

☐ Difficulty with Hearing

☐ Legally Deaf

☐ Tinnitus

☒ Vertigo

☐ Other

Vertigo

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☐ History

☒ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Do you lose your balance

☐ Yes

☒ No

comments

reports vertigo with sudden change in position, as well as onset without any activity

Do you have trouble hearing when people talk to you?

☐ Yes

☒ No

Do you wear a hearing aid?

☐ Yes

☒ No

Do you read lips?

☐ Yes

☒ No

Do you have ear pain or drainage?

☐ Yes

☒ No

Do you ever get dizzy?

- ☒ **Yes** ☐ **No**
- ↳ Does the room spin?
- ☒ **Yes** ☐ **No**
- ↳ Do you ever lose your balance?
- ☐ **Yes** ☒ **No**

Nose Problems (Nose Bleeds, Sinus infections, Other)

- ☐ **Yes** ☒ **No**

Mouth and Throat Problems (Difficulty Chewing, Difficulty Swallowing, Bleeding Gums, Other)

- ☒ **Yes** ☐ **No**

↳ Diagnoses

- ☐ Bleeding Gums ☐ Difficulty Chewing
- ☒ **Difficulty Swallowing** ☐ Other

Difficulty Swallowing

↳ Describe

- ☒ **Active** ☐ History of ☐ Rule out

↳ Have you had a stroke

- ☒ **Yes** ☐ **No**

comments

difficulty swallowing meats

↳ Do you eat a special diet

- ☐ **Yes** ☒ **No**

Neck Problems (parotid Disease, Carotid Stenosis, Other)

- ☒ **Yes** ☐ **No**

↳ Diagnoses

- ☒ **Carotid Stenosis** ☐ Parotid Disease
- ☐ Other

Carotid Stenosis

↳ Describe

- ☒ **Active** ☐ History of ☐ Rule out

↳ Supported by

- ☐ Bruits ☒ **History of TIAs** ☒ **Laboratory studies**
- ☐ Other

↳ Describe

- ☐ Right ☐ Left ☒ **Bilateral**

comments

on eliquis

Respiratory Problems (COPD, Emphysema, Asthma, Chronic Bronchitis Pneumonia, Other)

- ☐ **Yes** ☒ **No**

Cardiovascular (Hypertension, Angina, Ischemic Heart Disease(CAD), Myocardial Infarction, Other)

- ☒ **Yes** ☐ **No**

↳ Diagnoses

- ☐ Abnormal Cardiac Rhythm ☐ Aneurysm
- ☐ Angina ☒ **Atrial Fibrillation**

☐ Cardio – Respiratory Failure / Shock

☒ Congestive Heart Failure

☒ Hyperlipidemia

☐ Ischemic Heart Disease (CAD)

☐ Peripheral Vascular Disease

☐ Valvular Disease

Atrial Fibrillation

Describe

☒ Active

Type

☐ Paroxysmal

Supported by

☒ Medications

☐ History

Is patient taking

☒ Anticoagulant

History of

☐ Rule out

Chronic

☐ Unknown

ECG

☐ Symptoms

☐ Other

Electric cardioversion

☐ Other

Rate controlling medication

☐ Other

Congestive Heart Failure

Describe

☒ Active

Supported by

☒ Ejection fraction

☐ DOE

☐ Medications

Describe

☐ Diastolic

☐ Systolic

☒ Unknown

Secondary to Hypertension

☒ Yes

☐ No

Is patient on an ACE or ARB

☒ Yes

☐ No

Is patient on a Beta Blocker

☒ Yes

☐ No

Deep Vein Thrombosis

Describe

☐ Acute

☒ Chronic

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☐ Physical findings

☒ Use of anticoagulation

☐ Vascular studies

☐ Other

Vena Cava filter

☐ Edema

Use of anticoagulation

Describe

☒ Prophylactic

☐ Therapeutic

Persistent for three months or more

- ☒ **Yes** ☐ **No**
- Hyperlipidemia**
- ↳ **Describe**
- ☒ **Active** ☐ **History of** ☐ **Rule out**
- ↳ **Supported by**
- ☒ **Lab results** ☐ **Medication** ☐ **Other**
- ↳ **Is patient on Statin**
- ☐ **Yes** ☒ **No**

comments

managed with diet, not on statin due to report of increased cramping in legs

- Hypertension**
- ↳ **Describe**
- ☒ **Active** ☐ **History of** ☐ **Rule out**
- ↳ **Supported by**
- ☒ **Physical Exam** ☒ **Medications** ☐ **Symptoms**
- ☐ **Other**
- ↳ **Adequately controlled**
- ☒ **Yes** ☐ **No** ☐ **UnKnown**

History of Chest Pain

- ☐ **Yes** ☒ **No**

History of Intermittent Claudication

- ☐ **Yes** ☒ **No**

Implanted Pacemaker

- ☐ **Yes** ☒ **No**

Implanted Defibrillator

- ☐ **Yes** ☒ **No**

Do you have abnormal heart beats?

- ☒ **Yes** ☐ **No**

Does your heart race?

- ☐ **Yes** ☒ **No**

Do you sleep on more then one pillow?

- ☐ **Yes** ☒ **No**

have you ever have fluid in your lungs?

- ☐ **Yes** ☒ **No**

Do your legs or ankles swell up?

- ☒ **Yes** ☐ **No**

Do you follow a special diet?

- ☐ **Yes** ☒ **No**

Do you have headaches?

- ☐ **Yes** ☒ **No**

Do you feel light headed when you stand up?

- ☐ **Yes** ☒ **No**

Gastrointestinal Problems (Ulcer, Reflux, Hiatal Hernia, Colitis, Other)

- ☒ **Yes** ☐ **No**

↳ Diagnoses

- ☐ **Bowel Obstruction** ☐ **Cachexia**
- ☐ **Celiac Disease** ☐ **Cirrhosis**

- ☐ Colon Polyps

☐ Gall Bladder Disease

☒ GERD

☐ Inflammatory Bowel Disease

☐ Ulcer Disease
- ☐ Diverticulitis

☐ Gastroparesis

☐ Hepatitis

☐ Pancreatitis

☐ Other

GERD

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Heartburn /
Dyspepsia

☐ Regurgitation

☒ Medications

☐ Other

History of blood in stool

☐ Yes

☒ No

History of black stools

☐ Yes

☒ No

History of Heartburn / Dyspepsia

☒ Yes

☐ No

Describe

☒ Occasionally

☐ Chronic

History of Vomiting or Regurgitation

☐ Yes

☒ No

History of pain after eating

☐ Yes

☒ No

History of Jaundice

☐ Yes

☒ No

Do you follow a special diet?

☐ Yes

☒ No

Do you have frequent abnormal abdominal pain?

☐ Yes

☒ No

Do you have intermittent nausea or vomiting?

☐ Yes

☒ No

Do you have trouble with constipation?

☐ Yes

☒ No

Does diarrhea limit your ability to get out of the room or socially?

☐ Yes

☒ No

Do you see blood in your urine?

☐ Yes

☒ No

Do you have Frequent Stomach Pain

☐ Yes

☒ No

Bowel Movements

☐ Normal

☒ Abnormal

If abnormal

☐ Constipation

☐ Diarrhea

☒ Bowel Incontinence

Abdominal Openings

☐ Yes

☒ No

Rectal Problems

☐ Yes

☒ No

Last Bowel Movement

☐ Today

☒ 1-3 days ago

☐ >3 days ago

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

☒ Yes

☐ No

Diagnoses

- ☐ Alcohol Dependence

☐ Bipolar Disorder

☐ Cerebral Palsy

☒ Dementia

☐ Drug Dependence

☐ Generalized Anxiety Disorder

☒ Hemiparesis

☐ Insomnia

☐ Migraine Headaches

☐ Muscular Dystrophy

☐ Parkinson's disease

☐ Restless leg syndrome

☐ Seizure Disorder

☒ Stroke

☒ TIA

☐ Other
- ☐ Amyotrophic Lateral Sclerosis

☐ Cerebral Hemorrhage

☐ Delusional Disease

☐ Depression

☐ Fibromyalgia

☐ Guillain-Barre Disease

☐ Huntington's Chorea

☐ Intellectual and or Developmental Disability

☐ Multiple Sclerosis

☐ Myasthenia Gravis

☐ Peripheral Neuropathy

☐ Schizophrenia

☐ Spinal Cord Injury

☐ Subdural Hematoma

☐ Traumatic Brain Injury

Dementia

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Behavioral changes

☒ Mental testing

☐ MRI

☐ Functional changes

☐ Other

Type of Dementia

☐ Vascular

☐ Alzheimer's disease

☒ Etiology Unknown

Hemiparesis

Describe

☒ Active

☐ History Of

☐ Rule out

Describe

☐ Left sided

☒ Right sided

Supported by

☒ Physical findings

☐ History

☐ Other

comments

r/t cerebral infarct hx

Stroke

Describe

☐ Active

☒ History of

☐ Rule out

↳ Supported by

☒ Hospitalization
☐ Sensory findings

☒ Image study
☐ Other

☐ Physical findings

TIA

↳ Describe

☐ Active

☒ History of

☐ Rule out

↳ Supported by

☒ History
☐ Other

☒ Physical exam

☒ Image studies

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

☐ Yes

☒ No

Do you worry too much about different things?

☐ Yes

☒ No

Do you feel afraid that something bad might happen?

☐ Yes

☒ No

History of headaches

☐ Yes

☒ No

History of auditory hallucinations

☐ Yes

☒ No

History of visual hallucinations

☐ Yes

☒ No

History of psychotic behavior

☐ Yes

☒ No

History of episodes of delirium

☐ Yes

☒ No

Do you follow a special diet?

☐ Yes

☒ No

Do you have any weakness or deformity in your arms or legs that limits your ability to get around or do what you want to do?

☒ Yes

☐ No

Do you have trouble swallowing your food?

☒ Yes

☐ No

Do you have trouble making people understand you when you speak?

☐ Yes

☒ No

Do you trouble understanding what people say to you?

☐ Yes

☒ No

Do your hands shake?

☐ Yes

☒ No

Do you have convulsions and seizures?

☐ Yes

☒ No

Do you have trouble with your memory?

☐ Yes

☒ No

Do you have trouble finding words?

☐ Yes

☒ No

Do you have trouble sleeping?

☒ Yes

☐ No

Have you lost your appetite

- ☐ Yes ☒ No
 Do you hear voices or see things that other people do not
☐ Yes ☒ No
 Do you have highs and lows
☐ Yes ☒ No
 Do you ever feel like someone is out to get you
☐ Yes ☒ No
 How often do you go out to meet with family or friends
☐ Often ☒ Sometimes ☐ Never

GPCOG Score or MMSE Score

GPCOG Score	or MMSE Score

If GPCOG or MMSE is not done, is

- ☐ Patient oriented to person
☒ Yes ☐ No
☐ Patient oriented to place
☒ Yes ☐ No
☐ Patient oriented to time
☒ Yes ☐ No
☐ Recall
☒ Good ☐ Poor
☐ Patient describes recent news event
☒ Yes ☐ Partially ☐ No

Affect

- ☒ Normal ☐ Abnormal

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	Not at all	Several Days	More than half the days	Nearly every day
Feeling down, depressed or hopeless	Not at all	Several Days	More than half the days	Nearly every day

PHQ 2 Score

- ☒ < 3 ☐ 3 or more

Speech

- ☒ Normal ☐ Slurred ☐ Aphasic
☐ Apraxia

Finger to Nose

- ☒ Normal ☐ Abnormal

Heel (Shin) to Toe

- ☐ Normal

☒ **Abnormal**
- ☐ If abnormal

☐ Left

☐ Right

☒ **Both**

Thumb to Finger Tips

☒ **Normal**

☐ Abnormal

Sitting to Standing

☐ Normal

☐ Needs Assistance

☒ **Unable**

Facial / Extremity Movement

☐ Motor Tic☐ Intention Tremor☐ Spasticity☒ **Normal**

☐ Vocal Tic☐ Non-Intention (Pill rolling) Tremor☐ Chorea Movement☐ Benign (Essential Tremor)☐ Rigidity☐ Cog wheeling

Gait

☐ Normal☐ Abductor lurch☐ Ataxic☐ Limp☐ Paretic☒ **Other (Findings may also apply to Musculoskeletal diagnoses)**

☐ Wide based☐ Shuffling

comments

wheelchair bound

Genitourinary Problems (Overactive Bladder, Urinary Incontinence Stress Incontinence, Benign Prostatic Hypertrophy, Others)

☒ **Yes**

☐ No

- Diagnoses

☐ Acute Renal Failure☐ Chronic Kidney Disease☐ Erectile Dysfunction☐ Kidney Stones☒ **Urinary Incontinence**☐ Frequent UTI

☐ BPH☐ ESRD☒ **Frequent UTI**☐ Nephritis or Nephrosis☐ Other

Describe

☒ **Active**

Supported by

☐ Symptoms☐ Other

Urinary Incontinence

Describe

☒ **Active**

Supported by

☐ History☐ Medications☐ Biopsy

History of

☒ **Cultures**


☐ DME

Rule out

☒ **Laboratory results**

☐ Image studies

☐ Other

 FOCUSCARE

17

↳ **Related to stress**

☐ Yes

☒ **No**

↳ **Describe**

☒ **Daily**

☐ Few times a week

☐ Less than once a week

History of frequency

☐ Yes

☒ **No**

History of Nocturia

☐ Yes

☒ **No**

History of Hesitancy

☐ Yes

☒ **No**

Do you have trouble urinating?

☐ Yes

☒ **No**

Do you ever have blood in your urine?

☐ Yes

☒ **No**

Do you have any weakness or deformity in your arms or legs that limits your ability to get around or do what you want to do?

☒ **Yes**

☐ No

Do you have trouble holding your urine?

☒ **Yes**

☐ No

Do you trouble getting to the bathroom on time?

☒ **Yes**

☐ No

Do you ever have pain or burning during urination?

☐ Yes

☒ **No**

Do you ever wear pads or diapers?

☒ **Yes**

☐ No

Do you have a vaginal discharge?

☐ Yes

☒ **No**

Do you have vaginal bleeding?

☐ Yes

☒ **No**

Musculoskeletal Problems (Spinal Stenosis, Rheumatoid Arthritis, Gout, Osteoporosis, Others)

☒ **Yes**

☐ No

↳ **Diagnoses**

☐ Collagen (Connective) Tissue Disease

☒ **Degenerative Disc Disease**

☐ Extremity Fracture (other than Hip)

☒ **Gout**

☐ Hallux Valgus

☐ Hammer Toes

☐ Onychomycosis

☒ **Osteoarthritis**

☐ Osteomyelitis

☐ Osteoporosis

☐ Pyogenic Arthritis

☐ Rheumatoid Arthritis

☐ Spinal Stenosis

☐ Systemic Lupus Erythematosus

☐ Tinea Pedis

☐ Other

Degenerative Disc Disease

↳ **Describe**

☒ **Active**

☐ History of

☐ Rule out

- ↳ **Supported by**
 - ☐ Symptoms
 - ☐ Medications
 - ☒ **Physical Findings**
 - ☐ Other
 - ☒ **Image studies**
- ↳ **Normal bladder and bowel function**
 - ☐ Yes
 - ☒ **No**
- ↳ **Site of disease**
 - ☐ Cervical
 - ☐ Lumbosacral
 - ☐ Thoracic
 - ☐ Other
 - ☒ **Lumbar**
- Gout**
 - ↳ **Describe**
 - ☐ Active
 - ☒ **History of**
 - ☐ Rule out
 - ↳ **Supported by**
 - ☒ **History of attacks in**
 - ☒ **Lab tests**
 - ☐ Medications
 - ☐ Foot
 - ☐ Other
- Osteoarthritis**
 - ↳ **Describe**
 - ☒ **Active**
 - ☐ History of
 - ☐ Rule out
 - ↳ **Supported by**
 - ☒ **Symptoms**
 - ☒ **Physical Findings**
 - ☐ Image studies
 - ☐ Other
 - ↳ **Which joints**

comments

hands, knees

History / Finding of non- extremity Fracture

- ☐ Yes ☒ **No**

History / Finding of Hip Fracture / Dislocation

- ☒ **Yes** ☐ No

↳ Describe

- ☐ Active (within 16 weeks) ☒ **History of** ☐ Rule out

↳ Supported by

- ☒ **Hospitalization** ☐ Image studies ☐ Surgery

↳ Describe

- ☒ **Traumatic** ☐ Pathological

↳ Describe

- ☒ **Right** ☐ Left

comments

Hx hip and femur fractures > 2 years ago

History / Finding of Vertebral Fracture

- ☐ Yes ☒ **No**

Do you have any swelling of your joints?

- ☐ Yes ☒ **No**

Do you experience stiffness in the morning or during the day?

- ☒ **Yes** ☐ No

Do you have pain in your joints?

- ☒ **Yes** ☐ No

Do you have a problem straightening any joints?

- ☐ Yes ☒ **No**

Does pain and or swelling in your joints limit your activities?

☒ Yes ☐ No

Have you broken bones(fractures) in any parts of your body?

☒ Yes ☐ No

Do you have constant pain in your bones?

☒ Yes ☐ No

Have you had an amputation?

☐ Yes ☒ No

Integument Problems (Eczema, Psoriasis, Dermatitis, Urticaria, Other)

☐ Yes ☒ No

Endocrine Problems

☒ Yes ☐ No

↳ Diagnoses

- | | |
|---|--|
| <input checked="" type="checkbox"/> Chronic Kidney Disease secondary to Diabetes | <input type="checkbox"/> Coronary Artery Disease and Diabetes |
| <input type="checkbox"/> Cushing's Disease | <input checked="" type="checkbox"/> Diabetes |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Secondary Hyperparathyroidism |
| <input checked="" type="checkbox"/> Hypertension and Diabetes | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Kidney Stone |
| <input type="checkbox"/> Peripheral Neuropathy secondary to Diabetes | <input type="checkbox"/> Peripheral Vascular Disease secondary to Diabetes |
| <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Other |

Chronic Kidney Disease secondary to Diabetes

↳ Describe

☒ **Active** ☐ History of ☐ Rule out

↳ Supported by

☒ **Decreased GFR** ☐ Albuminuria ☐ Elevated BUN/ Creatinine

☐ Dialysis ☐ Other

↳ Patient on ACE or ARB

☒ **Yes** ☐ No

Diabetes

↳ Describe

☒ **Active** ☐ History of ☐ Rule out

↳ Supported by

☐ Symptoms ☐ Physical findings ☒ **Lab tests**

☒ **Medications** ☐ Other

↳ Type

☐ Type 1 ☒ **Type 2** ☐ Gestational

↳ Most recent Hb A1C, value

comments

unknown

↳ And Date

comments

unknown

↳ Met with a nurse or dietician for diabetic education

☒ **Yes** ☐ No

↳ Met with a diabetic educator

☐ Yes
 ☒ No

Hypertension and Diabetes

↳ Describe

☒ Active
 ☐ History of
 ☐ Rule out

↳ Supported by

☐ History
 ☒ Symptoms
 ☐ Physical Findings

☒ Medications
 ☒ Test results
 ☐ Image studies

☐ Biopsy
 ☐ DME
 ☐ Other

↳ Is patient on Ace or ARB

☒ Yes
 ☐ No

Do you periodically experience shakiness, lightheadedness, sweating, confusion, or blurred vision?

☒ Yes
 ☐ No

Do you often feel thirsty?

☐ Yes
 ☒ No

Do you have numbness or burning in your legs or feet?

☐ Yes
 ☒ No

Do you get pains in your leg or feet when you walk?

☒ Yes
 ☐ No

Do you get ulcers on your legs or feet?

☐ Yes
 ☒ No

Do you feel sluggish?

☐ Yes
 ☒ No

Do you sweat a lot or constantly feel hot?

☐ Yes
 ☒ No

Have you been told your kidneys are not working right, failing or shutting down?

☒ Yes
 ☐ No

Have you ever had dialysis?

☐ Yes
 ☒ No

Is your skin itchy?

☐ Yes
 ☒ No

Do you test your blood sugar?

☐ Yes
 ☒ No

Have you lost weight in the past 6 months?

☒ None
 ☐ 5lbs
 ☐ 10lbs

☐ 15lbs
 ☐ More than 15lbs
 ☐ 10% of your weight (calculated by assessor)

Hematology / Immunology / Infection Disease Problems (Anemia, easy bruising or abnormal bleeding Thrombocytopenia , Other)

☒ Yes
 ☐ No

↳ Diagnoses

☐ AIDS
 ☐ Anemia

☐ C. Difficile
 ☐ Community Acquired MRSA Infection

☐ HIV
 ☒ Herpes Zoster

☐ Hospital Acquired MRSA Infection
 ☐ Immune Deficiency

- ☐ Leukemia

☐ Multiple Myeloma

☐ Sickle Cell Disease

☐ Thalassemia

☐ Tuberculosis

☐ Other
- ☐ Lymphoma

☐ Sepsis

☐ Sickle Cell Trait

☐ Thrombocytopenia

☐ Vitamin D Deficiency

Herpes Zoster

Describe

☐ Active

Supported by

☒ Rash

☒ History of

☐ Rule out

☒ Symptoms

☐ Other

Easy bruising or abnormal bleeding

☐ Yes

☒ No

Long term anticoagulation use

☒ Yes

☐ No

Describe

☐ Aspirin

☐ Coumadin

☐ Thrombin Inhibitors
(Pradaxa)

☐ Plavix

☒ Factor Xa Inhibitors
(Xarelto, Eliquis)

☐ Other

Cancer

Diagnosis of Cancer	Yes	No
---------------------	-----	----

Pain

Does the patient experience pain?

☒ Yes

☐ No

Is the Pain Acute?

☐ Yes

☒ No

Is the Pain Chronic?

☒ Yes

☐ No

Describe

☒ Active

☐ History of

☐ Rule out

Where

knees, feet, hands

Do you take Methadone

☐ Yes

☒ No

What drug/s do you take for it

tylenol

How bad is your pain on a scale of one to ten with one being very mild and ten being severe

8

Is the Patient Undergoing Pain Management Planning?

☐ Yes ☒ No

Was the patient advised regarding the potential for dependence?

☒ Yes ☐ No

Is there any evidence of Maladaptive Behavior?

Tolerance?

☐ Yes ☒ No

Withdrawal?

☐ Yes ☒ No

Increased usage over a longer period that intended?

☐ Yes ☒ No

Desire or unsuccessful effort to cut down on use?

☐ Yes ☒ No

Excess time spent in activities to obtain the substance?

☐ Yes ☒ No

Continued use despite Doctor advice or patient knowledge of habituation?

☐ Yes ☒ No

Physical or Psychological Problem related to the substance use?

☐ Yes ☒ No

Vital Signs

Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
(mmHG)	(mmHG)	(bpm)				8

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	2 (Inch)	180 (lbs)	32.9

☒ **Obesity (BMI 30 – 34.9)** ☐ Moderate Obesity (BMI 35 – 39.9) ☐ Morbid Obesity (BMI = or > 40)
☐ Malnutrition (BMI < 18.5)

Exam Review

Constitutional

General appearance:	Normal	Abnormal
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Head and Face

Examination of head and face:	Normal	Abnormal
Palpation of the face and sinuses:	Normal	Abnormal

Eyes

Inspection of conjunctiva and lids:	Normal	Abnormal
Examination of pupils and irises:	Normal	Abnormal

Ears, Nose, Mouth and Throat

External Inspection of ears and nose:	Normal	Abnormal
Otoscopic examination:	Normal	Abnormal
Assessment of hearing:	Normal	Abnormal
Inspection of nasal mucosa, septum and trubينات:	Normal	Abnormal
Inspection of lips, teeth and gums:	Normal	Abnormal

Comment: no teeth

Examination of oropharynx:	Normal	Abnormal
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Neck

Examination of neck:	Normal	Abnormal
Examination of thyroid:	Normal	Abnormal

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
Percussion of chest:	Normal	Abnormal
Palpation of chest:	Normal	Abnormal
Auscultation of lungs:	Normal	Abnormal

Cardiovascular

Palpation of heart:	Normal	Abnormal
Auscultation of heart:	Normal	Abnormal
Carotid Arteries:	Normal	Abnormal
Abdominal Aorta:	Normal	Abnormal
Pedal Pulses:	Normal	Abnormal
Examination of Arterial Pulses:	Normal	Abnormal
Examination of Edema / Varicosities:	Normal	Abnormal

Lymphatic

Palpation of cervical nodes (neck)	Normal	Abnormal
Palpation of preauricular nodes (in front of the ears)	Normal	Abnormal
Palpation of Submandibular nodes (under jaw line/chin)	Normal	Abnormal

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
Comment: wheelchair bound		
Inspection/palpation of digits and nails:	Normal	Abnormal
Inspection/palpation of joints, bones and muscles:	Normal	Abnormal
Assessment of range of motion:	Normal	Abnormal
Comment: limited ROM all extremities		
Assessment of stability:	Normal	Abnormal
Comment: completely dependent w/ hoyers lift		
Assessment of muscle strength/tone:	Normal	Abnormal

Skin

Inspection of skin and subcutaneous tissue:	Normal	Abnormal
Palpation of skin and subcutaneous tissue:	Normal	Abnormal

Neurologic

Indicate specific cranial nerve tested

11 Accessory shrugs shoulder
12 hypoglossal

Indicate cranial nerve deficits found

Romberg Test	Normal	Abnormal
Examination of reflexes:	Normal	Abnormal
Examination of sensation:	Normal	Abnormal
Coordination:	Normal	Abnormal

Diabetes

Foot Exam:	Normal	Abnormal
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Psychiatric

Description of patient's judgement / insight:	Normal	Abnormal
Orientation of person, place and time:	Normal	Abnormal
Recent and remote memory:	Normal	Abnormal
Mood and affect:	Normal	Abnormal

Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnoses	Comments
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Home Safety & Personal Goals

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

- ☒ None
 ☐ Once
 ☐ Twice
 ☐ Three times
 ☐ More than three times

41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?	Yes	No
b. Do you have electrical cords running across floors, in doorways or under a rugs?	Yes	No
c. Do you have no slip mats on the shower floor or bath tub?	Yes	No
d. Do have adequate lighting in hallways and on the stairs?	Yes	No
e. Do you have handrails on staircases?	Yes	No
f. Is your hot water heater set for a maximum of 120 degrees?	Yes	No
g. Do you have smoke detectors on each level of the house and in all sleeping a rooms?	Yes	No
h. Do you have carbon Monoxide detectors on each level of the house?	Yes	No
i. Have used established an escape route in the event of fire?	Yes	No

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

walk again

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

find out what stopped her from walking

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

- ☐ Yes
 ☒ No

45. Feeling like harming others or yourself

- ☐ Yes
 ☒ No

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

- ☐ Yes
 ☒ No

Patient Summary



Assessors Comments :

Patient agreed to virtual visit. Patient identified by name, dob, and address. Areas of the assessment and cranial nerves not completed due to virtual visit. Patient and daughter requests for meals on wheels and physical/occupational therapy be resumed. Recommend speech therapy eval for new onset dysphagia. Patient and daughter both educated on importance of preventative screening. Please send

referral to VA Premier case management for meals on wheels, ot/pt and ST for new onset dysphagia

Member Acknowledgment

I have been advised by the evaluator and understand that the services performed by the evaluator are limited to the evaluation performed today; the evaluator has no further duties to me once the evaluation performed today is completed ; the evaluator is not liable for abandonment my refusing to provide me treatment or continuing care to me beyond this evaluation; and I should contact my primary care or treating physician for all questions and concerns regarding medical care and treatment or, in the event of an emergency, call 911

Member informed of acknowledgment	<input checked="" type="checkbox"/>
Date/Time of Service/Evaluation :	2021-06-09T10:58
Time exam finished	2021-06-09T11:54
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input checked="" type="checkbox"/>
Provider Signature	  Digitally signed by Jennifer B Bugg, FNP 2021-07-21, 08:33
Addendum	<div></div>

Disclosure Statement

Your health plan, has contracted with Focus Care to conduct a health exam on all of its Medicare members, including you. The health exam includes questions to help your health plan learn more about your current health. The exam may also find things that could effect your health. The results of the exam will help your health plan and your doctor keep you as healthy as possible.

Personal health information, or PHI, is information in your medical record that identifies the record as your record. PHI includes things like your date of birth, age, address, telephone number, and your medical history.

Most of the time, Focus Care will not release your personal information without your permission. Measures are in place to prevent your personal information from being accidentally released in writing, including by use of a computer, or orally. You may request more information about how your personal information is protected.

There are times when Focus Care is allowed to release your personal information without your permission. For example, your medical information may be given to other health care providers who take care of you. The results of this exam will be sent to your health plan and to your doctor.

Focus Care may release your personal health information to a 'business associate'. A 'business associate' is another agency that Focus Care uses to do

things, such as billing. We require our 'business associates' to have security measures in place to prevent your personal information from being accidentally released in writing, including by use of a computer, or orally.

Focus Care may be required to release your personal health information, without your permission, by law. including statutes, regulations, or valid court orders.

Focus Care will obtain your permission to use or release your personal health information for any other reason.

Do you have any questions about this information? Would you like to receive this information in a different language?

Your agreement to have this medical exam means you have given your permission to Focus Care to release the results of your medical exam to your health plan and to your doctor. Do you agree?