

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	LINWOOD G HOLT
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1958-06-01
Evaluation Date :	2021-7-14 08:00 AM
Visit Type :	

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICARE
LOB	DSNP
Name	LINWOOD G HOLT
Gender	Male
Address	600 WESTOVER HILL BLVD #B
City	RICHMOND
State	VA
Zip	23219-1410
Date of Birth	1958-06-01
Age(as of date)	63
Marital Status	Widowed
Member Identification Number	11001252
HICN	4RU8C69KW51
Phone Number	8042049775
Cell Number	8043096895
Alternate Contact Number	
Email	
Emergency Contact	Eula Harvey
Phone Number	804-398-3585
Primary Care Physician	JACKSON, RICHARD A
Phone Number	8042257148
PCP Address	304 E Leigh St
PCP City	Richmond
PCP State	VA

PCP Zip	232191410
PCP County	
Office ID	P0124311
Office Name	DOMINION MEDICAL ASSOCIATES INC

### 1. Race

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Caucasian      | <input checked="" type="checkbox"/> <b>African American</b> | <input type="checkbox"/> Asian                                     |
| <input type="checkbox"/> Latino         | <input type="checkbox"/> Native American                    | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Other                              |  |

### Patient's Ethnicity

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Hispanic          | <input checked="" type="checkbox"/> <b>Non-Hispanic</b> | <input type="checkbox"/> Other Ethnicity |
| <input type="checkbox"/> Prefer not to say |   |  |

### 2. Preferred language

- |  |                                |
|--|--------------------------------|
| <input checked="" type="checkbox"/> <b>English</b> | <input type="checkbox"/> 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?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Less than 3rd grade                    | <input type="checkbox"/> Completed 3rd grade | <input type="checkbox"/> Completed 8th grade |
| <input checked="" type="checkbox"/> <b>Completed 12th grade</b> | <input type="checkbox"/> 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

comments

Lives with his elderly roommate

12. Are you currently a caregiver for someone?

- ☒ **Yes**
☐ No

↳ Describe

Patients roommate is 88 years old and he helps to take care of him including buying groceries & assisting with some ADLs.

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

comments

Encouraged patient to quit smoking. Providing patient with education on quitting smoking.

## 14. Alcohol Use

☐ Current ☐ Former ☒ **Never**

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

☒ **Yes** ☐ No

Which drugs or medication

Current use: Marijuana: one blunt per day. Past use: used heroin for 5 years. Currently enrolled & attending a methadone clinic for his opioid dependence.

## 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
H. Going up or down stairs	No	Need Some Help	Need Total Help

## Medical History

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

☒ **None**

## 21. Are you currently seeing any specialists?

☒ Yes

☐ No

Medical Specialty	Specialist	For
Other	Hepatologist, Dr. Sterling	Hepatitis C
Infectious Disease Specialist	Dr. Dixon & Dr. Mahale	HIV

## 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](#)

Went to the ER for a cough January 2021

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

[If one or more, describe](#)

Hospitalized for 4 days during January 2021 for pneumonia

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

## 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

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

Chemotherapy	Yes	No	Unknown
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Catheter Care	Yes	No	Unknown
Oxygen	Yes	No	Unknown
Wound Care	Yes	No	Unknown
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	CHF, DM, Kidney failure	End organ failure
Father	Unknown	MI
Sibling1	DM, cancer, kidney failure	Unknown type of cancer

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	Yes
Breast Exam/Mammography	Not Applicable
Cervical Screening	Not Applicable
Bone Density	Not Applicable
Prostate Exam/PSA	Yes
If Diabetic Eye Exam	Not Applicable
If Diabetic Foot Exam	Not Applicable
If Diabetic Hgb A1c screen	Not Applicable
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

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

Provided patient education the flu vaccine and encouraged patient to receive the flu vaccine Fall 2021.

### 33. Have you been vaccinated for Pneumonia?

☒ Yes ☐ No

↳ Pneumovax

☒ Yes

☐ No

☐ Unknown

↳ Prevenar

☒ Yes

☐ No

☐ Unknown

### 34. Have you been vaccinated for Herpes Zoster?

☐ Yes ☒ No

comments

Providing education on the Herpes Zoster vaccine and encouraged patient to speak with his PCP.

## Allergies / Medications

### 35. Allergies

☐ Yes ☒ No

#### Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status
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comments

Denies taking suboxone. Patient taking Methadone 90mgs, prescribed by Dr. Krista Pine/Dr. K Suvdam.

HIV	DESCOVY	TAB 200/25MG	PO = By Mouth	QD	Dr. Dilip Mahale	Taking	Not Taking
HIV	TIVICAY	TAB 50MG	PO = By Mouth	QD	Dr. Daniel Nixon	Taking	Not Taking
Depression	MIRTAZAPINE	TAB 15MG ODT	Select	Select	Unknown	Taking	Not Taking
Drug addiction	SUBOXONE	MIS 8-2MG	Select	Select	Unknown	Taking	Not Taking
Nausea from HIV	PROMETHAZINE	TAB 25MG	PO = By Mouth	PRN	OTC	Taking	Not Taking
For taking Methadone	BUPREN/NALOX	MIS 8-2MG	N = Nasal	PRN	Dr. Catolico	Taking	Not Taking
Pneumonia	ALBUTEROL	FAT E	Select	Select	Unknown	Taking	Not Taking
BPH	FINASTERIDE	TAB 5MG	Select	Select	Unknown	Taking	Not Taking

### 36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
07-14-2021	Promethazine	Unknown	PO = By Mouth	PRN
07-14-2021	Advil Sinus	Unknown	PO = By Mouth	PRN

37. Chronic Use of

☒ None

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

Myopia

Describe

☒ Active☐ History of☐ Rule out

Supported by

☐ Symptoms☒ Glasses/ lenses☐ Other

comments

and Presbyopia

Do you wear glasses or contacts?

☒ Yes☐ No

Do you have trouble seeing even with glasses?

☐ Yes☒ No

Do you have problems seeing at night?

☐ Yes☒ No

Do you have eye pain?

☐ Yes☒ No

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

## Nose Problems (Nose Bleeds, Sinus infections, Other)

☒ Yes

☐ No

### Diagnoses

☐ Chronic Post Nasal Drip

☐ Nose Bleeds

☒ Sinus Infections

☐ Other

### Sinus Infections

#### Describe

☐ Active

☒ History Of

☐ Rule out

#### Supported by

☐ History

☐ Symptoms

☐ Physical Findings

☒ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

comments

Taking Advil sinus as needed

#### Exudate

☒ Clear

☐ Purulent

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

☐ Yes

☒ No

## Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes

☒ No

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

☒ Yes

☐ No

### Diagnoses

☐ Acute Pulmonary Embolism

☐ Acute Upper Respiratory Infection

☐ Asthma

☐ Chronic Pulmonary Embolism

☐ Chronic Respiratory Failure

☐ Chronic Sputum Production

☐ COPD

☐ Cystic Fibrosis

☐ Hypoventilation secondary to Obesity

☐ Hypoxemia

☒ Pneumonia

☐ Pulmonary Fibrosis

☐ Respirator Dependence/  
Tracheostomy Status

☐ Respiratory Arrest

☐ Sarcoidosis

☐ Sleep Apnea

☐ Other

### Pneumonia

#### Describe

☐ Active

☒ History of

☐ Rule Out

#### Supported by

☒ Hospitalization

☐ Physical findings

☐ Image studies

☐ Lab studies

☐ Other

#### Etiology

☐ Viral

☐ Pneumococcal

☐ Staph

☒ Other Bacterial

☐ Aspiration

#### History / finding of Lung abscess

☒ Yes

☐ No

History / finding of Empyema

☐ Yes

☒ No

Use of Oxygen

☐ Yes

☒ No

Shortness of breath

☐ Yes

☒ No

Wheezing

☐ Yes

☒ No

Chronic Cough

☐ Yes

☒ No

Patient requires durable medical equipment

☐ Yes

☒ No

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

☐ Yes

☒ No

comments

Denies hypertensive heart disease

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

☒ Yes

☐ No

Diagnoses

☐ Bowel Obstruction☐ Cachexia

☐ Celiac Disease

☒ Cirrhosis

☐ Colon Polyps

☐ Diverticulitis

☐ Gall Bladder Disease

☐ Gastroparesis

☐ GERD

☐ Hepatitis

☐ Inflammatory Bowel Disease

☒ Pancreatitis

☐ Ulcer Disease

☐ Other

Cirrhosis

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Symptoms☐ Physical findings

☒ Lab studies

☐ MRI☐ Biopsy

☐ Other

End Stage Liver Disease

☐ Yes

☒ No

Pancreatitis

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☐ Symptoms☐ Lab studies

☐ Alcoholism☐ Use of certain medications

☐ Family history

☒ Other

Other

Describe

comments

Hospitalization 2015 for pancreatitis. Denies chronic pancreatitis.

- ☐ Recurrent episodes
- ☐ Yes - Chronic ☒ No
- ☐ on a specific diet
- ☒ Yes ☐ No

comments

"Bland diet" - no acidic or spicy foods

### History of blood in stool

☐ Yes ☒ No

### History of black stools

☐ Yes ☒ No

### History of Heartburn / Dyspepsia

☐ Yes ☒ No

### 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

comments

Taking promethazine as needed. Reports he experiences nausea 2-3x/month and states it is from his HIV.

### 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

### 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

Depression

Describe

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

Supported by

- ☐ Symptoms
- ☐ PHQ 2 / 9
- ☒ **Use of antidepressant medication**

Other

comments

Took Mirtazapine in the past. Denies current use of Mirtazpine.

Major

- ☐ Yes
- ☒ **NO**

Drug Dependence

Describe

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

Supported by

- ☒ **Use of recreational drugs**
- ☐ History outpatient treatment
- ☐ Other
- ☐ Chronic use of pain medication
- ☐ Withdrawal symptoms
- ☐ History of hospitalization
- ☐ Abnormal affect

History of Psychosis

- ☐ Yes
- ☒ **No**

What drug/s

comments

Heroin

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

comments

Denies current and history of auditory hallucinations

History of visual hallucinations

☐ Yes

☒ No

comments

Denies current and history visual hallucinations

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

comments

Poor recall on PMH timeline/dates.

↳ 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	<input checked="" type="checkbox"/> Not at all	Several Days	More than half the days	Nearly every day
Feeling down, depressed or hopeless	<input checked="" type="checkbox"/> 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

Thumb to Finger Tips

☒ Normal ☐ Abnormal

Sitting to Standing

☒ Normal ☐ Needs Assistance ☐ Unable

Facial / Extremity Movement

☐ Motor Tic ☐ Vocal Tic ☐ Benign (Essential)

- ☐ Intention Tremor

☐ Tremor)

☐ Spasticity

☐ Non-Intention (Pill rolling) Tremor

☒ Normal

☐ Chorea Movement

☐ Rigidity

☐ Cog wheeling

Gait

- ☒ Normal

☐ Abductor lurch

☐ Ataxic

☐ Limp

☐ Paretic

☐ Other (Findings may also apply to Musculoskeletal diagnoses)

☐ Wide based

☐ Shuffling

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

☒ Yes

☐ No

Diagnoses

- ☐ Acute Renal Failure

☒ BPH

☐ Chronic Kidney Disease

☐ ESRD

☐ Erectile Dysfunction

☐ Frequent UTI

☐ Kidney Stones

☐ Nephritis or Nephrosis

☐ Urinary Incontinence

☐ Other

comments Denies nocturia

BPH

Describe

- ☐ Active

☒ History of

☐ Rule out

Supported by

- ☐ Physical exam

☐ Symptoms

☒ Medication

☐ Lab test

☐ Biopsy

☐ Hospitalization

☐ Other

comments Took finasteride in the past. Patient states he doesn't believe he needs it any longer and he talked with his PCP about not needing this medication any longer.

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

comments

Denies OA

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

☐ Yes

☒ No

comments

Denies current and history of open wounds

Endocrine Problems

☐ 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

☐ C. Difficile

☒ HIV

☐ Hospital Acquired MRSA Infection

☐ Leukemia

☐ Multiple Myeloma

☐ Sickle Cell Disease

☐ Thalassemia

☐ Tuberculosis

☐ Other

☐ Anemia

☐ Community Acquired MRSA Infection

☐ Herpes Zoster

☐ Immune Deficiency

☐ Lymphoma

☐ Sepsis

☐ Sickle Cell Trait

☐ Thrombocytopenia

☐ Vitamin D Deficiency

comments

Denies vitamin D deficiency and B vitamin deficiency

HIV

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Lab tests

☐ Symptoms

☒ Medications

☐ Other

comments Taking Tivicay and Descovy

↳ **Viral load**

comments Patient reports he had labs done 3 months ago & his viral load was not detected.

↳ **C4**

comments Patient states he does not know what his C4 level was when it was checked 3 months ago.

↳ **Patient currently symptomatic**

☐ Yes ☒ **No**

↳ **Is patient currently under active treatment**

☒ **Yes** ☐ No

### Easy bruising or abnormal bleeding

☐ Yes ☒ **No**

### Long term anticoagulation use

☐ Yes ☒ **No**

### Cancer

Diagnosis of Cancer	Yes	No
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### Pain

#### Does the patient experience pain?

☐ Yes ☒ **No**

comments Patient states he has been attending a methadone clinic for the past year after drug addiction for heroin. Denies maladaptive behavior.

### Vital Signs

#### Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
120 (mmHG)	66 (mmHG)	65 (bpm)	18	98	98	0

### BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	9 (Inch)	156 (lbs)	23.0

- ☐ 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
Examination of oropharynx:	Normal	Abnormal

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
Inspection/palpation of digits and nails:	Normal	Abnormal
Inspection/palpation of joints, bones and muscles:	Normal	Abnormal
Assessment of range of motion:	Normal	Abnormal
Assessment of stability:	Normal	Abnormal
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

I, II, III, IV, VI, VII, X, & XI by asking pt to read off his medications, blinking of eyes, performed fields of gaze, clinch their teeth, shrug shoulders, swallow, stick out his tongue, smile, tighten all facial muscles and move neck and extremities through ROM; Patient stood up, took steps forward and backwards.

Indicate cranial nerve deficits found

Cranial nerve deficit found due to vision difficulties.

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

Comment: Patient had difficulty with recall on dates when he was diagnosed and treated for his medical diagnosis.

Mood and affect:	Normal	Abnormal
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Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnosi s	Commen ts
DIGITAL_RETINAL_EXAM	No	Select			Select				
HBA1C	No	Select			Select				
MICROALBUMIN	No	Select			Select				
FOBT	Yes	Left Kit	330002979	330002979	Select				
DEXA	No	Select			Select				
PAD	No	Select			Select				
LDL	N/A	Select			Select				

Mini-Cog

39. Mini- Cog (see attached sheet)

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.1-3 For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test.

Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version : 1

Person's Answers: Banana, Sunrise & Chair

Word Recall :	3 Points	1 point for each word spontaneously recalled without cueing. Home Safety Yes
Clock Draw :	2 Points	Normal clock = 2 points. A normal clock has all numbers placed in the correct positions) with no missing or duplicate numbers. Hands are pointing to the 11 sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor Inability or refusal to draw a clock (abnormal) = 0 points.and 2 (11:10). Hand length is not scored.
Total Score :	5 Points	Total score = Word Recall score + Clock Draw score. A cut point of < 3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of < 4 is recommended as it may indicate a need for further evaluation of cognitive status.

## 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

Comment: No stairs

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?

Denies

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

Exercise and stop smoking

### 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 gave consent for the visit and was verified by stating his name and birthday. Patient was assessed with an in person visit.  
 Mr. Holt is a 63 year old male who has a PMH of HIV, opioid dependence,

depression, hepatitis C, depression, myopia and presbyopia. Patient states he has a history of depression and was seeing psychologist two years ago for treatment. He is not currently receiving treatment for depression. He states he knows he can go to the Daily Planet Medical offices any day to receive care if he starts to feel down, depressed or hopeless. Patient currently smokes cigarettes and marijuana. Encouraged patient to stop smoking and reviewed resources to quit. Patient is undergoing treatment hepatitis C at MCV hospital out patient services with Dr. Sterling. Pt has a past history of heroine use for 5 years. Patient currently is enrolled at a Methadone clinic & attends once per week. He has a Methadone prescription from Dr. Krista Pine/Dr. K. Suvdam at the Family Counseling Center for Recovery - Southlake. Patient sees his PCP every six months and has an appointment with his PCP in September 2021. Patient is concerned about his future living situation because he lives with/sub-rents from his roommate who is elderly. He is not on the lease and states if something happened to his roommate then he has no where to live. Submitted a non-urgent referral for follow-up.

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 :	2021-07-14T07:55
Time exam finished	2021-07-14T09:00
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Provider Signature	<div>Charlie Robinson, FNP-BC</div> <div>Digitally signed by Charlie Robinson, FNP 2021-07-14, 11:46</div>
Addendum	

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?