

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	CHERYL D JAMES
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1978-02-15
Evaluation Date :	2021-9-23 04:37 PM
Visit Type :	Virtual: Video & Audio Capability

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICARE
LOB	DSNP
Name	CHERYL D JAMES
Gender	Female
Address	2900 FENDALL AVENUE
City	RICHMOND
State	VA
Zip	23227-4359
Date of Birth	1978-02-15
Age(as of date)	44
Marital Status	
Member Identification Number	11001388
HICN	1E11TH5EQ31
Phone Number	8044413851
Cell Number	8043212812
Alternate Contact Number	
Email	
Emergency Contact	
Phone Number	
Primary Care Physician	RACKSON, KATHRYN
Phone Number	8042543500
PCP Address	2116 W Laburnum Ave Ste 100
PCP City	Richmond
PCP State	VA

PCP Zip	232274359
PCP County	Richmond City
Office ID	P0060414
Office Name	VCU CENTER FOR ADVANCED HEALTH

1. Race

- ☐ Caucasian
 ☐ African American
 ☐ Asian
 ☐ Latino
 ☐ Native American
 ☐ Native Hawaiian or other Pacific Islander
 ☐ Alaskan Native
 ☒ Other
- [Describe](#)
 Some of the most conditions

Patient's Ethnicity

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

2. Preferred language

- ☐ English
 ☒ Other
- [If other,](#)
- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> African languages | <input type="checkbox"/> Arabic | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> French | <input type="checkbox"/> French Creole | <input type="checkbox"/> German |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Gujarati | <input type="checkbox"/> Hebrew |
| <input type="checkbox"/> Hindi | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Italian |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Persian |
| <input type="checkbox"/> Polish | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Scandinavian Languages | <input type="checkbox"/> Serbo-Croatian | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Urdu | <input type="checkbox"/> Vietnamese |
| <input checked="" type="checkbox"/> Yiddish | | |

comments

Japanese

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

comments

Vaapings

14. Alcohol Use

- ☐ Current
 ☒ **Former**
☐ Never

How many drinks	How Often
3	Month

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

- ☐ Yes
 ☒ **No**

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

comments

None

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
C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
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
Catheter Care	Yes	No	Unknown
Oxygen	Yes	No	Unknown
Wound Care	Yes	No	Unknown
Regular Injections	Yes	No	Unknown

Tube Feedings	Yes	No	Unknown
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Family History

26. Family History

☐ Yes ☒ No

Preventive Care

27. In the past three years have you had?

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

comments

None

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

☐ Yes ☐ No ☒ NA

comments

None

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

☐ Yes ☐ No ☒ NA

comments

None

32. Do you get Flu Vaccine each year?

☐ Yes ☒ No

33. Have you been vaccinated for Pneumonia?

☐ Yes ☒ No

34. Have you been vaccinated for Herpes Zoster?

☐ Yes ☒ No

Allergies / Medications

35. Allergies

☐ Yes ☒ No

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
	NYSTOP	AER 250/50	PO = By Mouth	QOW		Taking	Not Taking
	NYSTATIN	TAB 10MG	SQ = Subcutaneous	HS		Taking	Not Taking
	KETOCONAZOLE	POW 100000	M = Intramuscular	PRN		Taking	Not Taking
	ALBUTEROL	CRE 100000	IV = Intravenous	BID		Taking	Not Taking
	HYDROCORT	SHA 0.02	N = Nasal	TID		Taking	Not Taking
	benazepril	NEB 0.00083	EA = Ear	QW		Taking	Not Taking

36. Over the Counter Medications / Supplements

☐ Yes ☒ No

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

☐ Glaucoma

☒ Macular Degeneration

☐ Retinal Disease
- Difficulty with vision

Hyperopia

Myopia

Others
- Cataracts

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ History

☒ Medications

☒ Biopsy

Symptoms

Test results

☒ DME

Physical Findings

Image studies

Other
- Secondary to Diabetes

☒ Yes

No
- Macular Degeneration

Describe

☐ Active

☐ History of

☒ Rule out

Supported by

☐ History

☒ Medications

☒ Biopsy

Symptoms

Test results

☒ DME

Physical Findings

Image studies

Other
- Describe

☒ Wet

☐ Dry

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

Legally Deaf

Describe

☐ Active

☒ History of

☐ Rule out

comments

htyty

Supported by

- ☒ History

☐ Medications

☐ Biopsy
- ☒ Symptoms

☒ Test results

☐ DME
- ☐ Physical Findings

☒ Image studies

☒ Other

comments

hnyjuyu

- Vertigo

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ History

☐ Medications

☒ Biopsy

☐ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☒ Image studies

☐ Other

Do you lose your balance

☐ Yes

☒ No

Other

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☒ History

☐ Medications

☒ Biopsy

☐ Symptoms

☒ Test results

☐ DME

☒ Physical Findings

☐ Image studies

☐ Other

Other

comments

hnhgjgyjty

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

Nose Problems (Nose Bleeds, Sinus infections, Other)

- ☒ Yes

☐ No

- Diagnoses

☒ Chronic Post Nasal Drip

☐ Sinus Infections

☒ Nose Bleeds

☐ Other

Chronic Post Nasal Drip

Describe

☐ Active

☐ History of

☒ Rule out

Supported by

☐ History

☒ Medications

☐ Biopsy

☐ Symptoms

☒ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

Nose Bleeds

Describe

☐ Active

☒ History of

☐ Rule out

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

☐ Yes

☐ No

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☒ Yes

☐ No

Diagnoses

☐ Carotid Stenosis

☐ Parotid Disease

☒ Other

Other

Describe

☒ Active

☐ History of

☐ Rule out

comments

gthyui

Supported by

☐ History

☒ Symptoms

☐ Physical Findings

☒ Medications

☒ Test results

☐ Image studies

☒ Biopsy

☐ DME

☒ Other

Other

Describe

comments

nhyu

Other

comments

vbghyuu

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

Acute Pulmonary Embolism

Describe

☒ Active (in past 6 months)

☐ History of

☐ Rule Out

Supported by

☒ Hospitalization for Pulmonary Embolism

☐ CT Angiogram

☒ Venous Doppler



FOCUSCARE

Pneumonia

 Active

Hospitalization

etiology

 **Viral**

Other Bacterial

☒ Yes

☒ Yes

 **Active**

- X-ray or CT results

Medications

 **Active**

- Use of CPAP

- Heavy snoring / restlessness during sleep

☒ Yes

☐ No

comments

Litere/min



 Night

 Continuous

□ Day

comments

Fine now

qbth

☒ Yes

☐ No☐ Yes

☐ No

☒ Yes☐ No☒ Yes

☐ No

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

☒ Yes

☐ No

Diagnoses

- ☒ Abnormal Cardiac Rhythm
- ☐ Angina
- ☐ Cardio – Respiratory Failure / Shock
- ☐ Congestive Heart Failure
- ☐ Hyperlipidemia
- ☒ Ischemic Heart Disease (CAD)
- ☒ Peripheral Vascular Disease
- ☐ Valvular Disease
- ☐ Aneurysm
- ☒ Atrial Fibrillation
- ☒ Cardiomyopathy
- ☐ Deep Vein Thrombosis
- ☒ Hypertension
- ☐ Myocardial Infarction
- ☐ Pulmonary Hypertension
- ☐ Other

Abnormal Cardiac Rhythm

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ ECG
- ☒ Electrophysiology procedure / cardioversion
- ☐ Use of rate controlling drug
- ☐ Other
- ☐ Use of anticoagulation

comments

ttrtuu

Describe

- ☐ Bradycardia
- ☐ Irregularly Irregular
- ☐ Tachycardia
- ☐ Premature contractures
- ☒ Regularly irregular

comments

thyyti

Does patient have Atrial Fibrillation

☒ Yes

☐ No

Atrial Fibrillation

Describe

- ☐ Active
- ☐ History of
- ☒ Rule out

comments

hjukyo

Type

- ☐ Paroxysmal
- ☒ Chronic
- ☐ Unknown

Supported by

- ☐ Medications
- ☐ History
- ☒ ECG
- ☒ Electric cardioversion
- ☐ Symptoms
- ☐ Other

Is patient taking

- ☐ Anticoagulant
- ☒ Rate controlling medication
- ☐ Other

Cardiomyopathy

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

☐ Echo ☒ Cardiac Cath ☐ Other

☐ Secondary to Hypertension

☐ yes ☒ No

comments

Hypertension

☐ Describe

☐ Active ☒ History of ☐ Rule out

☐ Supported by

☒ Physical Exam ☐ Medications ☐ Symptoms

☐ Other

comments

☐ Adequately controlled

☐ Yes ☒ No ☐ UnKnown

comments

Ischemic Heart Disease (CAD)

☐ Describe

☐ Active ☐ History of ☒ Rule out

☐ Supported by

☒ Cardiac Cath ☐ History of coronary stent ☒ Diagnosis of angina

☐ Medications ☐ History of CABG ☒ ECG

☐ Other

Peripheral Vascular Disease

☐ Describe

☒ Active ☐ History of ☐ Rule out

☐ Supported by

☒ Vascular studies ☒ Claudication ☒ Extremity Ulcers

☐ Diminished or absent pulses ☒ Amputation ☐ Other

☐ History Diabetes

☐ Yes ☒ No

comments

☐ Describe

☒ Ulceration ☐ Gangrene

comments

History of Chest Pain

☐ Yes ☒ No

History of Intermittent Claudication

☒ Yes ☐ No

comments

☐ Describe

☐ Complete heart block ☐ Sick sinus syndrome ☒ Bradycardia

☐ Other

comments

Implanted Pacemaker

☐ Yes ☒ No

Implanted Defibrillator

☒ Yes

☐ No

Describe

☐ Ventricular Tachycardia

☐ Asystole

☒ Cardiac Arrest

comments

uituuji

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

☐ Celiac Disease

☐ Colon Polyps

☐ Gall Bladder Disease

☐ GERD

☒ Inflammatory Bowel Disease

☐ Ulcer Disease

☐ Cachexia

☒ Cirrhosis

☒ Diverticulitis

☐ Gastroparesis

☒ Hepatitis

☐ Pancreatitis

☐ Other

Bowel Obstruction

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☒ Hospitalization

☒ Image studies

☒ Physical Findings

☐ Other

Cirrhosis

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Symptoms

☒ Physical findings

☒ Lab studies

☒ MRI

☐ Biopsy

☐ Other

End Stage Liver Disease

☐ Yes

☒ No

Diverticulitis

Describe

Active

History of

Rule out

Supported by

Colonoscopy

Image studies

Symptoms

Diet

Other

Abscess

Yes

No

Perforation

Yes

No

On a high fiber diet

Yes

No

Hepatitis

Describe

Active

History of

Rule out

Supported by

Symptoms

Physical findings

Lab studies

Other

Other

Describe

comments

hjtyy

Type

A

B

C

Describe

Acute

Chronic

Cirrhosis

Yes

No

Hepatocellular Carcinoma

Yes

No

comments

uiuii

Inflammatory Bowel Disease

Describe

Active

History of

Rule out

comments

ukyui

Supported by

Colonoscopy

Symptoms

Physical Findings

Medications

Other

Describe

Ulcerative Colitis

Crohn's Disease

Other

On a specific diet

Yes

No

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

Describe

☒ Right upper quadrant

☐ Epigastric

☐ Left upper quadrant

☐ Right lower quadrant

☐ Left lower quadrant

comments

right

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

comments

yjtyutyu

Do you see blood in your urine?

☐ Yes

☐ No

comments

yiiuyi

Do you have Frequent Stomach Pain

☐ Yes

☐ No

Bowel Movements

☒ Normal

☐ Abnormal

comments

juikluiu

Abdominal Openings

☐ Yes

☒ No

comments

yukui

Rectal Problems

☐ Yes

☒ No

comments

jikyui

Last Bowel Movement

☐ Today

☐ 1-3 days ago

☒ >3 days ago

comments

ghytyutyu

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

Alcohol Dependence

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☐ Drinking history

☒ **Hospitalizations**

☐ Physical findings

☐ Lab results

☐ Other

History of Delirium Tremens

☒ **Yes**

☐ No

History of Psychosis

☐ Yes

☒ **No**

Delusional Disease

Describe

☐ Active

☐ History of

☒ **Rule out**

Supported by

☐ Affect

☒ **Hospitalization**

☐ Other

☒ **Specific symptoms for 6 months or more**

☐ Medication

Generalized Anxiety Disorder

Describe

☐ Active

☐ History of

☒ **Rule out**

comments

ruled out

Supported by

☐ Symptoms

☒ **GAD 7**

☐ Antianxiety medication

☐ Other

Huntington's Chorea

- Describe

Active

History Of

Rule out

Supported by

Family history

Chorea movement

Physical findings

Other
- Muscular Dystrophy

Describe

Active

History Of

Rule out

Supported by

Physical findings

Biopsy

EMG's

History of progressive muscle weakness

Family history

Other
- Myasthenia Gravis

Describe

Active

History Of

Rule out

Supported by

Ptosis

Double vision

Difficulty chewing

Difficulty swallowing

Tensilon test

Medication

Other
- Peripheral Neuropathy

Describe

Active

History Of

Rule out

Supported by

Physical findings

EMG / Nerve Conduction studies

Biopsy

Other
- Secondary to Diabetes

Yes

No
- Seizure Disorder

Describe

Active

History of

Rule out

Supported by

History of recurrent seizures

Medications

Laboratory testing

Other
- Stroke

Describe

Active

History of

Rule out

Supported by

Hospitalization

Image study

Physical findings

Sensory findings

Other
- Physical findings

Physical findings

None

Right arm paralysis

Left arm paralysis

Right leg paralysis

Left leg paralysis

Right hemiparesis

Left hemiparesis

Aphasia

Apraxia

	<input type="checkbox"/> Cranial nerve paralysis	<input type="checkbox"/> Functional Quadriplegia
Are you nervous, anxious, feel on the edge or often feel stressed?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Do you worry too much about different things?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Do you feel afraid that something bad might happen?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
History of headaches		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
History of auditory hallucinations		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
History of visual hallucinations		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
History of psychotic behavior		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
History of episodes of delirium		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you follow a special diet?		
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Do you have trouble swallowing your food?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have trouble making people understand you when you speak?		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you trouble understanding what people say to you?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do your hands shake?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Do you have convulsions and seizures?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have trouble with your memory?		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have trouble finding words?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have trouble sleeping?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Have you lost your appetite		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you hear voices or see things that other people do not		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have highs and lows		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Do you ever feel like someone is out to get you		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> 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
012222	02222222

If GPCOG or MMSE is not done, is

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

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

hgjty

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

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ Physical exam
- ☐ Biopsy
- ☐ Other
- ☒ Symptoms
- ☒ Medication
- ☒ Lab test
- ☒ Hospitalization

Kidney Stones

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ History
- ☐ Medications
- ☒ Biopsy
- ☒ Symptoms
- ☐ Test results
- ☐ DME
- ☐ Physical Findings
- ☒ Image studies
- ☐ Other

Type

- ☐ Urate
- ☐ Other
- ☐ Calcium Oxalate
- ☒ Magnesium

Urinary Incontinence

Describe

- ☐ Active
- ☒ History of
- ☐ Rule out

Supported by

- ☐ History
- ☒ Symptoms
- ☐ Physical Findings

- ☐ Medications
- ☐ Biopsy
- ☒ Related to stress
 - ☒ Yes
 - ☒ Related to
 - ☐ Dribbling
 - ☒ Describe
 - ☐ Daily
- ☐ Test results
- ☐ DME
- ☐ No
- ☒ Image studies
- ☐ Other
- ☒ Urgency
- ☐ Other
- ☒ Few times a week
- ☐ Less than once a week

History of frequency

- ☐ Yes
- ☒ No

History of Nocturia

- ☒ Yes
- ☐ No



- ☐ 1x / night
- ☒ 2x / night
- ☐ 3x / night
- ☐ >=4x / night

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

☐ Pyogenic Arthritis

☒ Spinal Stenosis

☒ Tinea Pedis

Degenerative Disc Disease

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Symptoms

☒ Physical Findings

☐ Image studies

☐ Medications

☐ Other

Normal bladder and bowel function

☐ Yes

☐ No

Site of disease

☐ Cervical

☐ Thoracic

☒ Lumbar

☐ Lumbosacral

☐ Other

comments

hjjkyku

- Onychomycosis

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☒ History

☐ Symptoms

☒ Physical Findings

☐ Medications

☐ Test results

☒ Image studies

☐ Biopsy

☒ DME

☐ Other

Osteoporosis

Describe

☐ Active

☐ History of

☒ Rule out

Supported by

☒ Dexa scan

☒ Medications

☒ Imaging studies

☐ Symptoms

☐ Fracture history

☒ Other

Other

Describe
- comments
- jkiykhut
- Spinal Stenosis

Describe

☐ Active

☐ History of

☒ Rule out

Supported by

☒ Symptoms

☒ Physical Findings

☒ Image studies

☐ Medications

☐ Other

Normal bladder and bowel function

☒ Yes

☐ No

Tinea Pedis

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☒ History

☐ Symptoms

☒ Physical Findings

☐ Medications

☐ Test results

☒ Image studies

☐ Biopsy

☒ DME

☐ Other

 FOCUSCARE

24

History / Finding of non- extremity Fracture

- ☒ Yes
- ☐ No
- Describe

☐ Traumatic

☒ Pathological
- Describe

☐ Face

☒ Face

☐ Rib

☐ Pelvis

☐ Other
- Current (within 12 weeks)

☐ Yes

☒ No
- Describe fracture/s

History / Finding of Hip Fracture / Dislocation

- ☐ Yes
- ☐ No

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

Diagnoses

- ☒ Basil Cell Carcinoma
- ☐ Dermatitis
- ☒ Eczema
- ☐ Psoriasis
- ☐ Skin ulcer
- ☒ Urticarial Disease
- ☐ Wound
- ☒ Other

Basil Cell Carcinoma

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ History
- ☒ Symptoms
- ☐ Physical Findings
- ☒ Medications
- ☐ Test results
- ☒ Image studies
- ☒ Biopsy
- ☐ DME
- ☐ Other

Eczema

Describe

comments

☒ Active

☐ History of

☐ Rule out

Actie now

↳ Supported by

☐ History

☒ Symptoms

☐ Physical Findings

☒ Medications

☒ Test results

☐ Image studies

☒ Biopsy

☐ DME

☐ Other

Urticarial Disease

↳ Describe

☐ Active

☒ History of

☐ Rule out

comments

ghhgilg

↳ Supported by

☐ History

☒ Symptoms

☐ Physical Findings

☒ Medications

☒ Test results

☐ Image studies

☒ Biopsy

☐ DME

☐ Other

comments

Nhygj

↳ Type

☒ Acute

☐ Chronic

↳ Etiology

comments

ukukiyu

Other

↳ Describe

☒ Active

☐ History of

☐ Rule out

comments

kkjilui

↳ Supported by

☐ History

☒ Symptoms

☐ Physical Findings

☒ Medications

☐ Test results

☐ Image studies

☒ Biopsy

☐ DME

☐ Other

comments

kkjli;yu

↳ Other

comments

ulioyit

Do you have ulcers or wounds that require dressings?

☒ Yes

☐ No

Do you have a chronic skin condition?

☐ Yes

☒ No

Does your skin problem require the use of chronic medication, cream or ointment?

☒ Yes

☐ No

Do you get pains inyour legs when you walk that make you stop to get relief?

☐ Yes

☒ No

Do you have skin breakdown or ulcers around your ankles?

☒ Yes

☐ No

Endocrine Problems

☒ Yes

☐ No

↳ Diagnoses

☒ Chronic Kidney Disease
secondary to Diabetes

☐ Coronary Artery Disease and
Diabetes

☐ Cushing’s Disease

☒ Diabetes

- ☐ Diabetic Retinopathy

☒ Hypertension and Diabetes

☒ Hypothyroidism

☒ Peripheral Neuropathy secondary to Diabetes

☐ Hyperparathyroidism
- ☒ Secondary Hyperparathyroidism

☐ Hyperthyroidism

☐ Kidney Stone

☐ Peripheral Vascular Disease secondary to Diabetes

☐ 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

comments

bkgukhuy

- Supported by

☒ Symptoms

☒ Physical findings

☒ Lab tests

☐ Medications

☐ Other

comments

ukgtyut

- Type

☐ Type 1

☒ Type 2

☐ Gestational

comments

Conditions

- Most recent Hb A1C, value

comments

hyty

- And Date

comments

ugkil

- Met with a nurse or dietician for diabetic education

☒ Yes

☐ No

comments

kyuo

- Met with a diabetic educator

☐ Yes

☒ No
- Secondary Hyperparathyroidism
- Describe

☐ Active

☐ History of

☒ Rule out
- Supported by

☒ History Chronic Kidney Disease

☒ History Vitamin D Deficiency

☐ History Celiac Disease

☒ Malabsorption

☐ Bariatric Surgery

☒ Lab tests

☐ History of kidney stones

☐ History of Fractures

☒ Imaging studies

☐ Fatigue

☐ Other
- Hypertension and Diabetes
- Describe

☐ Active

☒ Supported by

☒ History

☐ Medications

☐ Biopsy

☒ Is patient on Ace or ARB

☐ Yes

Hypothyroidism

☒ Describe

☐ Active

☒ Supported by

☒ Weight gain

☐ Depression

☐ Other

☐ History of

☐ Symptoms

☐ Test results

☒ DME

☒ No

☐ Rule out

☒ Physical Findings

☒ Image studies

☐ Other

☐ Active

☒ History of

☐ Rule out

☒ Fatigue

☒ Treatment for hypothyroidism

☐ Lab data

Peripheral Neuropathy secondary to Diabetes

☒ Describe

☐ Active

☒ Supported by

☒ Physical exam

☐ Surgical procedures

☐ Patient sees Podiatrist

☐ Yes

☐ History of

☒ Skin lesions

☐ Other

☒ No

☐ Rule out

☒ Foot deformity

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)

comments

gntyjuy

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

AIDS

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out
- ☐ Symptoms
- ☒ Physical findings
- ☒ History of opportunistic infections

- ☐ Medications
- ☐ Other

Is patient currently under treatment

- ☒ Yes
- ☐ No

Where

comments

yiiioyou

Herpes Zoster

Describe

- ☐ Active
- ☒ History of
- ☐ Rule out
- ☐ Symptoms
- ☒ Rash
- ☐ Other

Hospital Acquired MRSA Infection

Describe

- ☐ Active
- ☐ History of
- ☒ Rule out
- ☐ Hospitalization
- ☒ Medications
- ☐ Other
- ☒ Physical findings
- ☒ Cultures

comments

ttrrt

Multiple Myeloma

Describe

- ☐ Active

☒ **History of**

☐ Rule out

☒ **Symptoms**

☒ **Lab tests**

☐ Other

Support by

☐ History of

☐ Rule out

Describe

☐ Other

Active

☐ Rule out

Family history

☐ Other

Thalassemia

☐ Rule out

Describe

☐ Rule out

Active

☐ Rule out

Family history

☐ Rule out

History of infections

☐ Rule out

Symptoms

☐ Rule out

Lab tests

☐ Rule out

comments

gyiypi

- ☐ Active

☐ History of active TB

☐ TB Infection (positive PPD)

☒ **Rule out active TB**

☐ Other

Support by

☐ History

☐ Medications

☐ Imaging study

☐ Skin test

☐ Symptoms

☐ Positive culture

☐ Other

Has patient been given BCG

☐ Yes

☐ No

☐ Unknown

Has patient been treated for active Tuberculosis

☐ Yes

☐ No

☐ Unknown

Has patient been treated for TB Infection

☐ Yes

☐ No

☐ Unknown

Easy bruising or abnormal bleeding

- ☒ **Yes**

☐ No

comments

lhlhyt

Long term anticoagulation use

- ☒ **Yes**

☐ No

- Describe

☐ Aspirin

☐ Coumadin

☒ **Thrombin Inhibitors (Pradaxa)**

☐ Plavix

☐ Factor Xa Inhibitors (Xarelto, Eliquis)

☐ Other

comments

jhggyuty

Cancer

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

Describe

- ☒ **Active**

☐ History of

☐ Rule out

Supported by

- ☒ Physical findings
☐ Lab tests
☐ Biopsy
☐ Other
☐ Describe ghugy
- ☐ Hospitalization
☐ Imaging studies
☒ Other
- ☒ Treatments
☒ Surgery

Type

- ☐ Brain
☐ Breast
☐ Stomach
☐ Colon
☐ Bladder
☐ Prostate
☐ Lymph Nodes
- ☐ Head
☐ Lung
☒ Liver
☐ Rectum
☐ Ovaries
☐ Bone
☐ Skin
- ☐ Neck
☐ Esophagus
☐ Pancreas
☐ Kidney
☐ Uterus
☐ Blood
☐ Other

☐ Specific type/s

ghytyjt

☐ Stage or Classification specific to the cancer

yhyukui

Active treatment

- ☐ Yes
- ☒ No

History / Finding of Metastasis

- ☒ Yes
- ☐ No

☐ Location
ukyuit

☐ To Cancer, history / finding of Cachexia
☒ Yes ☐ No

comments

tyutyk

Do you see a specialist?

- ☐ Yes
- ☒ No

comments

hgguk

Pain

Does the patient experience pain?

- ☒ Yes
- ☐ No

comments

Description of patient's judgement / insight:

Is the Pain Acute?

- ☒ Yes
- ☐ No

Is the Pain Chronic?

- ☒ Yes
- ☐ No

☐ Describe

☐ Active ☐ History of ☒ Rule out

comments Ruled out

↳ Where

In hospital

↳ Do you take Methadone

☐ Yes ☒ No

↳ What drug/s do you take for it

fggthh

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

yjukiu

Is the Patient Undergoing Pain Management Planning?

☒ Yes ☐ No

comments uyl0o;0;

↳ Is the Patient Responding to the Pain Management Plan?

☒ Yes ☐ No

comments ytklo;o

Was the patient advised regarding the potential for dependence?

☒ Yes ☐ No

comments ytkluiliuklikkujytuthgutuythu

Is there any evidence of Maladaptive Behavior?
Tolerance?

☐ Yes ☒ No

comments hikliu;i9o

Withdrawal?

☐ Yes ☒ No

comments bmmhjkuioi

Increased usage over a longer period that intended?

☐ Yes ☒ No

comments hyuloioo

Desire or unsuccessful effort to cut down on use?

☐ Yes ☒ No

comments h.iuloui

Excess time spent in activities to obtain the substance?

☐ Yes ☒ No

comments ggkj.oli

Continued use despite Doctor advice or patient knowledge of habituation?

☐ Yes ☒ No

comments iirtryr

Physical or Psychological Problem related to the substance use?

☐ Yes

☒ No

comments

nnjioguiug

Vital Signs

Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
02 (mmHG)	03 (mmHG)	100 (bpm)	99	199	99	3

BMI

comments

Examination of head and face:

Patients Height		Patients Weight	Calculate BMI
02 (Feet)	02 (Inch)	700 (lbs)	728.0

- ☐ 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
---------------------	--------	----------

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
----------------------	--------	----------

Comment: Abnormal

Examination of thyroid:	Normal	Abnormal
-------------------------	--------	----------

Comment: NBHJKJ

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

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
------------	--------	----------

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

Comment:

uuui

Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnosi s	Commen ts
DIGITAL_RETINAL_EXAM	Yes	Left Kit			Yes	08-17-2021	9		
HBA1C	No	Refused Kit	90232123	90232123	No	08-23-2021	10		
MICROALBUMIN	N/A	Mail Kit Direct to member	23123190	23123190	Member Refused	09-29-2021	2		
FOBT	Yes	Refused Kit	23190000	23190000	Exception		All Virtually capable		
DEXA	No	Completed Kit with Member			Yes		9		
PAD	N/A	Completed Kit with Member			No		22		
LDL	No	Refused Kit	23109123	23109123	Member Refused	08-24-2021	23.		

on the floor that could cause tripping?		
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?

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

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 :

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 :	
Time exam finished	
I accept the Disclosure Statement	<input checked="" type="checkbox"/>

Consented to Video chat	<input checked="" type="checkbox"/>
Provider Signature	<div><div>shwe</div><div>Digitally signed by test clinicianFE, FNP 2022-02-25, 16:20</div></div>
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?