

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	LAWRENCE PRETOPAPA
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1950-09-08
Evaluation Date :	2021-2-27 11:00 AM
Visit Type :	In Person

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	Medicare
LOB	DSNP
Name	LAWRENCE PRETOPAPA
Gender	Male
Address	151 SAMFORD ST
City	ALBERTA
State	VA
Zip	238219999
Date of Birth	1950-09-08
Age(as of date)	71
Marital Status	Single
Member Identification Number	11002878
HICN	4J05CD1XM60
Phone Number	4349497949
Cell Number	7577796900
Alternate Contact Number	
Email	
Emergency Contact	Dorothy Peterson (friend)
Phone Number	4345329257
Primary Care Physician	KHAN, ABUDR
Phone Number	7574957420
PCP Address	4221 Pleasant Valley Rd Ste 114
PCP City	Virginia Beach
PCP State	VA

PCP Zip	234648519
PCP County	
Office ID	P0125466
Office Name	PLEASANT VALLEY MEDICAL CENTER

### 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

comments

tee

↳ How Many

- ☐ 1 - 3 a day ☐ 1/2 a pack ☐ 1 pack  
☐ More than 1 pack ☐ Other

14. Alcohol Use

☐ Current
 ☐ Former
 ☒ **Never**

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

☐ Yes
 ☐ No

comments

Previous substance use

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

↳ 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

Medical Specialty	Specialist	For
Gastroenterologist		Liver disease

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

A. Seen your PCP	None	1	2	3	4	5 or more
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Comment: Visits Q3-6months, recent Virtual visit (Feb 2021)

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

 Describe

Liver complications

### 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

## Family History

### 26. Family History

☐ Yes

☐ No

comments

Denies any significant medical issues

## Preventive Care

### 27. In the past three years have you had?

Screen	Answer
Colonoscopy	No
Breast Exam/Mammography	Not Applicable
Cervical Screening	Not Applicable
Bone Density	No
Prostate Exam/PSA	Yes
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

### 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

comments

Unknown

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

☒ Yes

☐ No

☐ NA

comments

Hx Hepatitis C (resolved with previous Tx)

### 32. Do you get Flu Vaccine each year?

☐ Yes ☒ No

### 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

## Allergies / Medications

### 35. Allergies

☐ Yes ☒ No

### Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
2021-02-27	Lactulose	15ml	PO = By Mouth	QD		Taking	Not Taking
2021-02-27	Xifaxan	550mg	PO = By Mouth	BID		Taking	Not Taking
2021-02-27	Midodrine	10mg	PO = By Mouth	TID		Taking	Not Taking
2021-02-27	Neurontin	300mg	PO = By Mouth	BID		Taking	Not Taking
2021-02-27	Januvia	25mg	PO = By Mouth	QD		Taking	Not Taking
2021-02-27	Omeprazole	20mg	PO = By Mouth	QD		Taking	Not Taking
2021-02-27	Lantus	28 units	SQ = Subcutaneous	QD		Taking	Not Taking
2021-02-27	Ferrous Sulfate	325mg	PO = By Mouth	TID		Taking	Not Taking
2021-02-27	Atorvastatin	40mg	PO = By Mouth	QD		Taking	Not Taking

### 36. Over the Counter Medications / Supplements

☐ Yes ☒ No

### 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

#### 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

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

☐ Yes ☒ No

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

☐ Yes ☒ No

#### 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

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

☒ Yes ☐ No

#### Diagnoses

- |   |  |
|---|--|
| <input type="checkbox"/> Abnormal Cardiac Rhythm        | <input type="checkbox"/> Aneurysm            |
| <input type="checkbox"/> Angina                         | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Cardio – Respiratory Failure / | <input type="checkbox"/> Cardiomyopathy      |



- Shock
- ☐ Congestive Heart Failure

☐ Deep Vein Thrombosis
- ☐ Hyperlipidemia

☐ Hypertension
- ☐ Ischemic Heart Disease (CAD)

☐ Myocardial Infarction
- ☐ Peripheral Vascular Disease

☐ Pulmonary Hypertension
- ☐ Valvular Disease

☒ Other

Other

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☒ History

☒ Symptoms

☐ Physical Findings
- ☒ Medications

☐ Test results

☐ Image studies
- ☐ Biopsy

☐ DME

☐ Other

comments

Hypotension

Other

comments

Tx Midodrine

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

☐ Diverticulitis

- ☐ Gall Bladder Disease
- ☒ GERD
- ☐ Inflammatory Bowel Disease
- ☐ Ulcer Disease
- ☐ Gastroparesis
- ☒ Hepatitis
- ☐ Pancreatitis
- ☒ Other

GERD

- ☒ Describe
  - ☒ Active
- ☐ History of
- ☐ Rule out
- ☒ Supported by
  - ☒ Heartburn / Dyspepsia
  - ☐ Other
- ☐ Regurgitation
- ☐ Medications

comments

Tx Omeprazole

Hepatitis

- ☒ Describe
  - ☒ Active
- ☐ History of
- ☐ Rule out
- ☒ Supported by
  - ☒ Symptoms
  - ☐ Other
- ☐ Physical findings
- ☒ Lab studies
- ☒ Type
  - ☐ A
  - ☐ B
  - ☒ C
- ☒ Describe
  - ☒ Acute
- ☐ Chronic
- ☒ Cirrhosis
  - ☒ Yes
  - ☐ No
- ☐ Hepatocellular Carcinoma
  - ☐ Yes
  - ☒ No

Other

- ☒ Describe
  - ☒ Active
- ☐ History of
- ☐ Rule out
- ☒ Supported by
  - ☒ History
  - ☒ Medications
  - ☐ Biopsy
- ☒ Symptoms
- ☐ Physical Findings
- ☐ Test results
- ☐ Image studies
- ☐ DME
- ☐ Other
- ☒ Other

comments

Liver disease (Cirrhosis)--Tx Xifaxan, Lactulose

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

## 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

## 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

## 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

comments

Virtual, limited exam

### Thumb to Finger Tips

- ☒ Normal
 ☐ Abnormal

### Sitting to Standing

- ☐ Normal
 ☐ Needs Assistance
 ☒ Unable

comments

Bilat amputee, unable to stand

### Facial / Extremity Movement

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

comments No Lower Extremities, Bilat amputation

## Gait

- |   |  |                                     |
|---|--|-------------------------------------|
| <input type="checkbox"/> Normal         | <input type="checkbox"/> Limp  | <input type="checkbox"/> Wide based |
| <input type="checkbox"/> Abductor lurch | <input type="checkbox"/> Paretic   | <input type="checkbox"/> Shuffling  |
| <input type="checkbox"/> Ataxic         | <input checked="" type="checkbox"/> Other (Findings may also apply to Musculoskeletal diagnoses) |                                     |

comments Nonambulatory

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

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

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

- |   |                             |
|---|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|-----------------------------|

### Diagnoses

- |   |   |
|---|---|
| <input type="checkbox"/> Collagen (Connective) Tissue Disease | <input type="checkbox"/> Degenerative Disc Disease    |
| <input type="checkbox"/> Extremity Fracture (other than Hip)  | <input type="checkbox"/> Gout                         |
| <input type="checkbox"/> Hallux Valgus                        | <input type="checkbox"/> Hammer Toes                  |
| <input type="checkbox"/> Onychomycosis                        | <input type="checkbox"/> Osteoarthritis               |
| <input type="checkbox"/> Osteomyelitis                        | <input type="checkbox"/> Osteoporosis                 |
| <input type="checkbox"/> Pyogenic Arthritis                   | <input type="checkbox"/> Rheumatoid Arthritis         |
| <input type="checkbox"/> Spinal Stenosis                      | <input type="checkbox"/> Systemic Lupus Erythematosus |
| <input type="checkbox"/> Tinea Pedis                          | <input checked="" type="checkbox"/> Other             |

### Other

#### Describe

- |  |                                     |                                   |
|--|-------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|--|-------------------------------------|-----------------------------------|

#### Supported by

- |   |  |   |
|---|--|---|
| <input checked="" type="checkbox"/> History | <input checked="" type="checkbox"/> Symptoms | <input checked="" type="checkbox"/> Physical Findings |
| <input type="checkbox"/> Medications        | <input type="checkbox"/> Test results        | <input type="checkbox"/> Image studies                |
| <input type="checkbox"/> Biopsy             | <input type="checkbox"/> DME                 | <input type="checkbox"/> Other                        |

#### Other

comments Bilat Lower Extrem amputation, nonambulatory

## History / Finding of non- extremity Fracture

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

## History / Finding of Hip Fracture / Dislocation

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

## History / Finding of Vertebral Fracture

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

## Do you have any swelling of your joints?

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

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

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> 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 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 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   |

Diabetes

↳ Describe

☒ Active ☐ History of ☐ Rule out

↳ Supported by

☒ Symptoms ☐ Physical findings ☒ Lab tests  
☒ Medications ☐ Other

comments

Tx Januvia, Lantus

↳ Type

☐ Type 1 ☒ Type 2 ☐ Gestational

↳ Most recent Hb A1C, value

comments

Unknown

↳ And Date

comments

??

↳ Met with a nurse or dietician for diabetic education

☐ Yes ☒ No

↳ Met with a diabetic educator

☐ Yes ☒ No

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

☐ Yes ☒ No

Do you often feel thirsty?

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Do you have numbness or burning in your legs or feet?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Do you get pains in your leg or feet when you walk?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Do you get ulcers on your legs or feet?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Do you feel sluggish?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Do you sweat a lot or constantly feel hot?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Have you been told your kidneys are not working right, failing or shutting down?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Have you ever had dialysis?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Is your skin itchy?		
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Do you test your blood sugar?		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you lost weight in the past 6 months?		
<input checked="" type="checkbox"/> None	<input type="checkbox"/> 5lbs	<input type="checkbox"/> 10lbs
<input type="checkbox"/> 15lbs	<input type="checkbox"/> More than 15lbs	<input type="checkbox"/> 10% of your weight (calculated by assessor)

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

☒ Yes ☐ No

#### Diagnoses

- |   |  |
|---|--|
| <input type="checkbox"/> AIDS                             | <input checked="" type="checkbox"/> Anemia                 |
| <input type="checkbox"/> C. Difficile                     | <input type="checkbox"/> Community Acquired MRSA Infection |
| <input type="checkbox"/> HIV                              | <input type="checkbox"/> Herpes Zoster                     |
| <input type="checkbox"/> Hospital Acquired MRSA Infection | <input type="checkbox"/> Immune Deficiency                 |
| <input type="checkbox"/> Leukemia                         | <input type="checkbox"/> Lymphoma                          |
| <input type="checkbox"/> Multiple Myeloma                 | <input type="checkbox"/> Sepsis                            |
| <input type="checkbox"/> Sickle Cell Disease              | <input type="checkbox"/> Sickle Cell Trait                 |
| <input type="checkbox"/> Thalassemia                      | <input type="checkbox"/> Thrombocytopenia                  |
| <input type="checkbox"/> Tuberculosis                     | <input type="checkbox"/> Vitamin D Deficiency              |
| <input type="checkbox"/> Other                            |  |

#### Anemia

##### Describe

☒ Active

☐ History of

☐ Rule out

##### Supported by

☒ Lab tests

☐ Symptoms

☐ History of blood transfusion

☐ Other

##### Etiology

- |   |  |  |
|---|--|--|
| <input checked="" type="checkbox"/> Iron deficiency | <input type="checkbox"/> Pernicious      | <input type="checkbox"/> Kidney disease    |
| <input type="checkbox"/> Hemolysis                  | <input type="checkbox"/> Aplastic        | <input type="checkbox"/> Chemotherapy      |
| <input type="checkbox"/> Blood loss                 | <input type="checkbox"/> Chronic Disease | <input type="checkbox"/> Folate Deficiency |
| <input type="checkbox"/> Other                      |  |  |

↳ If yes, Patient on

- |   |                                |                                     |
|---|--------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> Iron    | <input type="checkbox"/> B 12  | <input type="checkbox"/> Folic Acid |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Other |                                     |

comments

Tx Ferrous Sulfate

Easy bruising or abnormal bleeding

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

Long term anticoagulation use

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

Cancer

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

Pain

Does the patient experience pain?

- |   |                             |
|---|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|-----------------------------|

Is the Pain Acute?

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

Is the Pain Chronic?

- |   |                             |
|---|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|-----------------------------|

↳ Describe

- |  |                                     |                                   |
|--|-------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|--|-------------------------------------|-----------------------------------|

↳ Where

Bilat Phantom Leg pain

↳ Do you take Methadone

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

↳ What drug/s do you take for it

Tx Neurontin  
No Opioids/narcotics

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

Varies , today 3/10

Is the Patient Undergoing Pain Management Planning?

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

Was the patient advised regarding the potential for dependence?

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

Is there any evidence of Maladaptive Behavior?

Tolerance?

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> 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)				3/10

### BMI

comments Unknown Height--was 5'8 prior to Bilat amputation 3yrs ago

Patients Height		Patients Weight	Calculate BMI
(Feet)	(Inch)	120 (lbs)	

- ☐ 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

Comment: Virtual, limited exam

### Eyes

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

Comment:

Virtual, limited exam

Ears, Nose, Mouth and Throat

External Inspection of ears and nose:	Normal	Abnormal
Otoscopic examination:	Normal	Abnormal

Comment:

Virtual, limited exam

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

Comment:

Virtual, limited exam

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
Percussion of chest:	Normal	Abnormal

Comment:

Virtual, limited exam

Palpation of chest:	Normal	Abnormal
Auscultation of lungs:	Normal	Abnormal

Cardiovascular

Palpation of heart:	Normal	Abnormal
---------------------	--------	----------

Comment:

Virtual, limited exam

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

Comment:

Virtual, limited exam

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:

Nonambulatory

Inspection/palpation of digits and nails:	Normal	Abnormal
---	--------	----------

Comment:

Virtual, limited exam

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

Comment:

Virtual, limited exam

Neurologic

Indicate specific cranial nerve tested

CN (3, 4, 6), (5, 7, 8, 10, 11, 12)--appears WNL (virtual)

Indicate cranial nerve deficits found

Virtual, limited exam

Romberg Test	Normal	Abnormal
--------------	--------	----------

Comment:

N/A

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

Comment:

Bilat Amputee (nonambulatory)

Diabetes

Foot Exam:	Normal	Abnormal
------------	--------	----------

Comment:

N/A (Bilat amputee)

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
DIGITAL_RETINAL_EXAM	Yes	Left Kit			Yes	02-16-2022	gggghgh	hhjhj	Virtual, no screenings
HBA1C	Yes	Left Kit	11112222	11112222	No	02-24-2022	kjkjjk	jjkjjk	jkjkkllj
MICROALBUMIN	Yes	Refused Kit	32323232	32323232	No	02-25-2022	hjhjhj	kkjjk	jjkjkkjkj
FOBT	Yes				No				
DEXA	N/A				No				
PAD	Yes				No				
LDL	No				No				

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, Chair, Sunrise**

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
--	-----	----

Comment: Nonambulatory

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?

Mobility

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

Increased mobility (Bilat amputee)

### 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 :


Annual Health Assessment, responses provided by member (Lawrence). Also, some assistance provided by Caretaker (Kim Grant).  
He is reportedly feeling well overall, despite some extensive chronic medical issues. He is Bilat Lower Extrem Amputee with Liver issues & DM. He's currently stable on current Tx & denies any new complaints/concerns/complications.  
Previous Hepatitis C related to substance abuse/addiction, now resolved since rec'd Tx.

\*\*Virtual visit, therefore some blank responses due to limited assessment info.

\*\*Verification: Name/DOB

## 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 :	2021-02-27T11:14
Time exam finished	2021-02-27T11:57
I accept the Disclosure Statement	
Consented to Video chat	<input checked="" type="checkbox"/>
Provider Signature	<div> <div>Temeka Gillespie</div> <div>  <div>Digitally signed by Temeka Gillespie, FNP 2021-03-25, 19:10</div> </div> </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?