

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	ROBERT ASHERMAN
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1970-04-27
Evaluation Date :	2021-7-26 09:00 AM
Visit Type :	

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICARE
LOB	DSNP
Name	ROBERT ASHERMAN
Gender	Male
Address	409 RIVERMONT AVE
City	LYNCHBURG
State	VA
Zip	24501-2652
Date of Birth	1970-04-27
Age(as of date)	51
Marital Status	Divorced
Member Identification Number	11004531
HICN	4CW6D09VU51
Phone Number	4346107967
Cell Number	4344776064
Alternate Contact Number	
Email	
Emergency Contact	Karen Jennings
Phone Number	434-610-7967
Primary Care Physician	Lori Nelson-Madison
Phone Number	
PCP Address	2323 Memorial Ave
PCP City	Lynchburg
PCP State	VA

PCP Zip	245012652
PCP County	
Office ID	P9338926
Office Name	CENTRA MEDICAL GROUP

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
- ☐ Describe

12. Are you currently a caregiver for someone?

- ☐ Yes
- ☒ No

13. Tobacco use

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

comments

2-3 ppd

14. Alcohol Use

☐ Current
 ☒ **Former**
☐ Never

comments

unsure when he quit but states years ago and was a binge drinker.

How many drinks	How Often
Select	Select

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

☒ **Yes**
☐ No

Which drugs or medication

diclofenac, acetaminophen, gabapentin, ibuprofen

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

comments

Karen Jennings helps him get food when he needs it.

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	Karen Jennings, mental health case worker	schizophrenia
Psychiatrist	Dr. Wilson, Horizon	schizophrenia
Ophthalmologist	Dr. Billa	routine eye visits
Gastroenterologist	Dr. Clark, Lynchburg gastroenterology	GERD
ENT	Blue ridge ENT	nasal congestion
Neurologist	Centra Neurology	peripheral neuropathy
Pulmonologist	Dr. Baker, LPA	emphysema, asthma, OSA
Cardiologist	Centra cardiology	CAD
Other	OrthoVA	spinal fracture
Other	Dr. Chirachetti, Centra pain management	chronic pain, peripheral neuropathy

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](#)

GI symptoms
Gout

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](#)

thoracotomy 4/2020
psychiatric issues

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

Physical Therapist	Yes	No
Comment: for spinal fracture, but therapy was stopped early because he was waiting for approval from VPHP. Needs new PT referral.		
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

Comment:

Invega monthly

Tube Feedings	Yes	No	Unknown
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Family History

26. Family History

☒ Yes

☐ No

Family Member	Medical Condition	Cause of Death
Father	diabetes, prostate CA, CAD	
Mother	stroke, CAD, MS	

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	Yes
Prostate Exam/PSA	Yes
If Diabetic Eye Exam	No
If Diabetic Foot Exam	No
If Diabetic Hgb A1c screen	No
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

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

Substance	Reaction
Haldol	elevated liver enzymes

Medications

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

Invega injection monthly

Anxiety	LORAZEPAM	TAB 0.5MG	PO = By Mouth	PRN	Dr. Wilson	Taking	Not Taking
Schizophrenia	INVEGA SUST	INJ 156MG/ML	M = Intramuscular	Select	Dr. Wilson	Taking	Not Taking
Pain	GABAPENTIN	TAB 600MG	PO = By Mouth	TID	Dr. Chirachetti	Taking	Not Taking
HLD	ATORVASTATIN	TAB 80MG	PO = By Mouth	QPM	Dr. Nelson-Madison	Taking	Not Taking
Pain	DICLOFENA	TAB 75MG	PO = By	PRN	Dr.	Taking	Not Taking

	C	DR	Mouth		Chirachetti		
emphysema	ADVAIR DISKU	AER 500/50	PO = By Mouth	BID	Dr. Nelson-Madison	Taking	Not Taking
schizophrenia	BENZTROPI NE	TAB 2MG	PO = By Mouth	BID	Dr. Wilson	Taking	Not Taking
emphysema/asthma	ALBUTEROL SUL	90 mcg	PO = By Mouth	PRN	Dr. Nelson Madison	Taking	Not Taking
Pain	BACLOFEN	TAB 10MG	PO = By Mouth	QD	Dr. Chirachetti	Taking	Not Taking
GERD	OMEPRAZOL E	CAP 20MG	PO = By Mouth	QD	Dr. Nelson Madison	Taking	Not Taking
gout	ALLOPURIN OL	TAB 100MG	PO = By Mouth	QD	Dr. Nelson madison	Taking	Not Taking
allergic rhinitis	AZELASTINE	SPR 0.001	N = Nasal	QD	Dr. Nelson Madison	Taking	Not Taking
CAD	METOPROL	TAB 50MG ER	PO = By Mouth	QD	Dr. nelson madison	Taking	Not Taking
constipation	polyethylene glycol	one packet	PO = By Mouth	PRN	Dr. Nelson Madison	Taking	Not Taking
pain	acetaminoph en	500 mg	PO = By Mouth	PRN	Dr. Nelson madison	Taking	Not Taking
dry eyes	Restasis	0.05%	E = Eye	PRN	Dr. Villa	Taking	Not Taking
allergic rhinitis	loratadine	10 mg	PO = By Mouth	QD	Dr. Nelson Madison	Taking	Not Taking
OP	aledronate sodium	70 mg	PO = By Mouth	QW	Dr. Nelson Madison	Taking	Not Taking
CAD	aspirin	81 mg	PO = By Mouth	QD	Dr. Nelson madison	Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ Yes
☐ No

Date	Description	Dose/Units	Route	Frequency
	ibuprofen	400 mg	PO = By Mouth	prn
	Multivit	1 tab	PO = By Mouth	qd
	Fish oil	1000 mg	PO = By Mouth	qd
	Vit D	50 mcg	PO = By Mouth	qd
	Calcium	1200 mg	PO = By Mouth	qd

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	Yes	No

told to you by the doctor or pharmacist?		
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

Others

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ History

☒ Medications

☐ Biopsy

☒ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

Other

comments

Dry eyes, uses Restasis PRN

Do you wear glasses or contacts?

☐ 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

☐ Sinus Infections

☐ Nose Bleeds

☒ Other

Other

Describe

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

comments

allergic rhinitis, uses lorantidine and nasal spray

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
- ☒ **Asthma**
- ☐ Chronic Respiratory Failure
- ☒ **COPD**
- ☐ Hypoventilation secondary to Obesity
- ☐ Pneumonia
- ☐ Respirator Dependence/Tracheostomy Status
- ☐ Sarcoidosis
- ☐ Other
- ☐ Acute Upper Respiratory Infection
- ☐ Chronic Pulmonary Embolism
- ☐ Chronic Sputum Production
- ☐ Cystic Fibrosis
- ☐ Hypoxemia
- ☐ Pulmonary Fibrosis
- ☐ Respiratory Arrest
- ☒ **Sleep Apnea**

Asthma

Describe

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

Supported by

- ☐ Wheezing
- ☒ **Use of Bronchodilator**
- ☐ Other
- ☒ **Chronic Cough**
- ☐ Use of Inhaled or oral steroids
- ☐ Cyanosis
- ☐ Use of ventilator

Is patient on controller medications

- ☒ **Yes**
- ☐ No

Does patient use rescue medications

- ☒ **Yes**
- ☐ No

Does patient have current exacerbation

- ☐ Yes
- ☒ **No**

COPD

Describe

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

Supported by

☐ Use of accessory muscles

☐ Wheezing

☐ Dyspnea on exertion

☐ Barrel Chest

☐ Clubbing

☐ O2 use

☐ Respirator

☐ Other

☐ XR results

☐ Decreased or prolonged breath sounds

☒ Brinchodilator medication

☐ Yes

☒ No

☐ Yes

☐ No

☐ Yes

☐ No

☒ Inhaled

☐ Nebulizer

☐ Oral

☐ Yes

☒ No

☐ Yes

☒ No

Has patient been told they have Chronic Bronchitis

Has patient been told they have Emphysema

Is patient on Bronchodilator

Route is

Is patient on Steroids

Does patient have current exacerbation

Sleep Apnea

Describe

Supported by

History of

Positive sleep studies

Other

Rule out

History of sleepiness during the day

Heavy snoring / restlessness during sleep

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

Diagnoses

☐ Abnormal Cardiac Rhythm

☐ Angina

☐ Aneurysm

☐ Atrial Fibrillation

- | | |
|---|---|
| <input type="checkbox"/> Cardio – Respiratory Failure / Shock | <input type="checkbox"/> Cardiomyopathy |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Deep Vein Thrombosis |
| <input checked="" type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Hypertension |
| <input checked="" type="checkbox"/> Ischemic Heart Disease (CAD) | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Valvular Disease | <input type="checkbox"/> Other |

Hyperlipidemia

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☐ Lab results

☒ **Medication**

☐ Other

Is patient on Statin

☒ **Yes**

☐ No

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

comments

takes metoprolol and aspirin daily

History of Chest Pain

☒ **Yes**

☐ No

Describe

☒ **Achy**

☐ Sharp

☐ Tight

☐ Crushing

Does pain go into left arm

☐ Yes

☒ **No**

Is pain reproduced or worsened when touching chest or costochondral junctions

☐ Yes

☒ **No**

Is pain brought on by

☐ Exertion

☐ Eating

☐ Stress / Anxiety

☐ Other

comments

unpredicted onset

Is pain relieved by oral medication

☐ Yes

☒ **No**

comments

pt sits and resolves after 15-20 minutes

History of Intermittent Claudication

☒ **Yes**

☐ No

Describe

☐ Complete heart block

☐ Sick sinus syndrome

☐ Bradycardia

☐ Other

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

comments

three

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☐ Gastroparesis

☒ GERD☐ Hepatitis

☐ Inflammatory Bowel Disease☐ Pancreatitis

☐ Ulcer Disease☒ Other

↳ Describe

☒ Active☐ History of☐ Rule out

↳ Supported by

☐ Heartburn /
Dyspepsia☒ Regurgitation☒ Medications

☐ Other

comments

takes omeprazole and symptoms improved

Other

↳ Describe

☒ Active☐ History of☐ Rule out

↳ Supported by

☐ History☒ Symptoms☐ Physical Findings

☒ Medications☐ Test results☐ Image studies

☐ Biopsy☐ DME☐ Other

↳ Other

comments

Constipation, takes miralax prn

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

☐ Describe

☐ Blood ☒ Bile ☐ Coffee grounds
☐ Other

History of pain after eating

☐ Yes ☒ No

History of Jaundice

☐ Yes ☒ No

Do you follow a special diet?

☐ Yes ☒ No

Do you have frequent abnormal abdominal pain?

☐ Yes ☒ No

Do you have intermittent nausea or vomiting?

☒ Yes ☐ No

Do you have trouble with constipation?

☒ Yes ☐ No

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

☐ Yes ☒ No

Do you see blood in your urine?

☐ Yes ☒ No

Do you have Frequent Stomach Pain

☐ Yes ☒ No

Bowel Movements

☐ Normal ☒ Abnormal

☐ If abnormal

☒ Constipation ☐ Diarrhea ☐ Bowel Incontinence

☐ If Constipation

☐ Acute ☒ Chronic

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

Generalized Anxiety Disorder

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Symptoms

☐ GAD 7

☒ Antianxiety medication

☐ Other

Schizophrenia

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Affect

☐ Specific symptoms for 6 months or more

☒ Medication

☐ Hospitalization

☐ Psychosis

☐ Other

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

☒ Yes

☐ No

Do you worry too much about different things?

☒ Yes

☐ No

Do you feel afraid that something bad might happen?

☒ Yes

☐ No

History of headaches

☐ Yes

☒ No

History of auditory hallucinations

☐ Yes

☒ No

History of visual hallucinations

- ☐ Yes ☒ No
 History of psychotic behavior
- ☐ Yes ☒ No
 History of episodes of delirium
- ☐ Yes ☒ No
 Do you follow a special diet?
- ☐ Yes ☒ No
 Do you have any weakness or deformity in your arms or legs that limits your ability to get around or do what you want to do?
- ☐ Yes ☒ No
 Do you have trouble swallowing your food?
- ☐ Yes ☒ No
 Do you have trouble making people understand you when you speak?
- ☐ Yes ☒ No
 Do you have 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
- ☐ Often ☒ Sometimes ☐ Never
 How often do you go out to meet with family or friends

GPCOG Score or MMSE Score

GPCOG Score	or MMSE Score

If GPCOG or MMSE is not done, is

- ☒ Patient oriented to person ☐ No
- ☒ Patient oriented to place ☐ 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

Thumb to Finger Tips

☒ Normal☐ Abnormal

Sitting to Standing

☒ Normal☐ Needs Assistance☐ Unable

Facial / Extremity Movement

☐ Motor Tic☐ Vocal Tic☐ Benign (Essential Tremor)

☐ Intention Tremor☐ Non-Intention (Pill rolling) Tremor☐ Rigidity

☐ Spasticity☐ Chorea Movement☐ Cog wheeling

☒ Normal

Gait

☒ Normal☐ Limp☐ Wide based

☐ Abductor lurch☐ Paretic☐ Shuffling

☐ Ataxic☐ Other (Findings may also apply to Musculoskeletal diagnoses)

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

☐ Yes☒ No

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

☒ Yes☐ No

- ↳ Diagnoses

☐ Collagen (Connective) Tissue Disease

☐ Degenerative Disc Disease

☐ Extremity Fracture (other than Hip)

☒ Gout

☐ Hallux Valgus

☐ Hammer Toes

☐ Onychomycosis

☐ Osteoarthritis

☐ Osteomyelitis

☒ Osteoporosis

☐ Pyogenic Arthritis

☐ Rheumatoid Arthritis

☐ Spinal Stenosis

☐ Systemic Lupus Erythematosus

☐ Tinea Pedis

☐ Other
- Gout

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☐ History of attacks in Foot

☐ Lab tests

☒ Medications

☐ Other
- Osteoporosis

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☒ DEXA scan

☒ Medications

☐ Imaging studies

☐ Symptoms

☒ Fracture history

☐ Other

comments

vertebral compression fracture in 4/2020

History / Finding of non- extremity Fracture

☐ Yes☒ No

History / Finding of Hip Fracture / Dislocation

☐ Yes☒ No

History / Finding of Vertebral Fracture

☒ Yes☐ No

- ↳ Describe

☐ Active (within 12 weeks)

☒ History of

☐ Rule out

↳ Supported by

☐ Hospitalization

☒ Image studies

☐ Surgery

↳ Describe

☐ Traumatic

☒ Pathological

↳ Spinal Cord Injury

☐ Yes

☒ No

↳ Describe vertebrae/s and fracture type

thoracic spine

Do you have any swelling of your joints?

☐ Yes ☒ No

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

☒ Yes ☐ No

Do you have pain in your joints?

☐ Yes ☒ No

Do you have a problem straightening any joints?

☐ Yes ☒ No

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

☐ Yes ☒ No

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

☐ Yes ☒ No

Do you have constant pain in your bones?

☐ Yes ☒ No

Have you had an amputation?

☐ Yes ☒ No

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

☐ Yes ☒ No

Endocrine Problems

☐ Yes ☒ No

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

Cancer

Diagnosis of Cancer	Yes	No
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Pain

Does the patient experience pain?

☒ Yes ☐ No

Is the Pain Acute?

☐ Yes ☒ No

Is the Pain Chronic?

☒ Yes ☐ No

Describe

☒ Active

☐ History of

☐ Rule out

Where

spine/back
gout

Do you take Methadone

☐ Yes ☒ No

What drug/s do you take for it

gabapentin, diclofenac, acetaminophen, ibuprofen

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

8/10

Is the Patient Undergoing Pain Management Planning?

☒ Yes ☐ No

Is the Patient Responding to the Pain Management Plan?

☒ Yes ☐ No

comments states medications help but has been told he will have chronic pain.

Was the patient advised regarding the potential for dependence?

☐ Yes ☒ No

Is there any evidence of Maladaptive Behavior?

Tolerance?

☐ Yes ☒ No

Withdrawal?

☐ Yes ☒ No

Increased usage over a longer period that intended?

☐ Yes ☒ No

Desire or unsuccessful effort to cut down on use?

☐ Yes ☒ No

Excess time spent in activities to obtain the substance?

☐ Yes ☒ No

Continued use despite Doctor advice or patient knowledge of habituation?

☐ Yes ☒ No

Physical or Psychological Problem related to the substance use?

☐ Yes ☒ No

Vital Signs

Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
140 (mmHG)	84 (mmHG)	72 (bpm)	12	98.1	95	8/10

BMI

Patients Height		Patients Weight	Calculate BMI
6 (Feet)	2 (Inch)	242 (lbs)	31.1

- ☒ **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 turbinates:	Normal	Abnormal
Inspection of lips, teeth and gums:	Normal	Abnormal

Comment: edentulous

Examination of oropharynx:	Normal	Abnormal
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Neck

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

Pulmonary

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

Cardiovascular

Palpation of heart:	Normal	Abnormal
Auscultation of heart:	Normal	Abnormal

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

Lymphatic

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

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
Inspection/palpation of digits and nails:	Normal	Abnormal
Inspection/palpation of joints, bones and muscles:	Normal	Abnormal

Comment: left great toe with swelling. No redness

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

II: visual acuity intact III: EOM intact IV: EOM intact V: sensation intact to light touch on face VI: EOM intact VII: symmetric eye closing, symmetric facial movement VIII: hearing intact on gross exam X: uvula midline XI: shoulder shrugs equal bilaterally XII: full ROM with tongue
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Indicate cranial nerve deficits found

none

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

Coordination:	Normal	Abnormal
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Diabetes

Foot Exam:	Normal	Abnormal
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Psychiatric

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

Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnosis	Comments
DIGITAL_RETINAL_EXAM	No	Select			No				
HBA1C	No	Select			No				
MICROALBUMIN	No	Select			No				
FOBT	Yes	Refused Kit			No		done by GI		
DEXA	N/A	Select			No				
PAD	Yes	Select			Yes		right Normal 1.17, left normal 1.23	rule out pad	
LDL	No	Select			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,

Word Recall :	1 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 :	3 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

Do you worry about falling or feeling unsteady when standing or walking

☒ Yes

☐ No

Worries about falling or feeling unsteady when standing or walking?

☒ Yes

☐ No

comments

sometimes

Did you have a fracture in past 6 months?

☐ Yes

☒ No

41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?	Yes	No
b. Do you have electrical cords running across floors, in doorways or under a rugs?	Yes	No
c. Do you have no slip mats on the shower floor or bath tub?	Yes	No
d. Do have adequate lighting in hallways and on the stairs?	Yes	No
e. Do you have handrails on staircases?	Yes	No
f. Is your hot water heater set for a maximum of 120 degrees?	Yes	No
Comment: unknown		
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?

Would like to feel better

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

stop smoking

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

☒ Yes

☐ No

comments

as child

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 :

Face to Face visit was completed. Pt was identified with name and date of birth. Pt verbally provided their height and weight. Any blanks left in this assessment were unable to be completed during this assessment today. Pt was informed that their PCP would receive a copy of this assessment.

Education: Pt education provided regarding diet and its impact on chronic disease. We discussed dietary change he could make. Also gave him options of food pantries in local area if lack of food is an issue.


Tobacco: Discussed the impact that smoking has on health and I recommended discussing with PCP smoking cessation options.

Patient has chronic back pain and was undergoing physical therapy but this was stopped due to transportation and scheduling issues. Due to his pain and diagnosis, he would greatly benefit from physical therapy and strengthening program.

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 :	2021-07-26T09:00
Time exam finished	2021-07-26T11:14

I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Provider Signature	<div><div>Jennifer Edwards</div><div>Digitally signed by Jennifer E Edwards, AGNP 2021-07-26, 11:16</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?