

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	JOYCE LUNDY
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1948-09-11
Evaluation Date :	2021-7-13 08:00 AM
Visit Type :	In Person

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICARE
LOB	DSNP
Name	JOYCE LUNDY
Gender	Female
Address	2304 S BUCKNER STREET
City	PETERSBURG
State	VA
Zip	23803-5039
Date of Birth	1948-09-11
Age(as of date)	72
Marital Status	Single
Member Identification Number	11004747
HICN	2G79N18MR19
Phone Number	8048616405
Cell Number	8048358690
Alternate Contact Number	
Email	
Emergency Contact	Doreen Lundy; Andrea Lundy
Phone Number	804-324-9357; 804-926-9843
Primary Care Physician	DUHART, HAROLD BOBBY
Phone Number	8049579601
PCP Address	541 S Sycamore St
PCP City	Petersburg
PCP State	VA

PCP Zip	238035039
PCP County	
Office ID	P0060327
Office Name	PETERSBURG HEALTH CARE ALLIANCE

### 1. Race

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

### Patient's Ethnicity

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

### 2. Preferred language

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

## Previously Documented Conditions

## Covid Screening

In the last 14 days, have you:

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

## Self-Assessment and Social History

### 3. How much school have you completed?

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

comments

some 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
14. Alcohol Use

☐ Current☐ Former☒ Never
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

↳ 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
Nephrologist	Satish Bankuru	ESRD
Gastroenterologist	Maryann Williams	GERD
Cardiologist	Dr. Islam El Juadee	atrial fibrillaion, CAD

Ophthalmologist	Dr. Foster	cataracts
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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

SCI injury

C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
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If one or more, describe

back surgery; rehab until February 2021

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

If one or more, describe

back surgery December 2020

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

☒ Yes ☐ No

Describe  
asthma exacerbation

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

Physical Therapist	Yes	No
Comment: with Heaven Sent in Chester, VA rehab at Encompass Health		
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
Comment: 5 days a week; and every other Saturday		
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

Family Member	Medical Condition	Cause of Death
Father	esophageal cancer	cancer
Mother	HTN, CVA, sinusitis; OA	passed at 89yo

Preventive Care

27. In the past three years have you had?

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

28. Last colonoscopy if more than 2 years ago

☐ 3 – 5 years ago ☒ 6 – 10 years ago ☐ > 10 years ago  
☐ Never ☐ Don't know

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

comments

covid immunization x2 (last shot 5/12/21)

## Allergies / Medications

### 35. Allergies

☒ Yes ☐ No

Substance	Reaction
lisinopril	swelling, cough
tramado	hallucinations

## Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
gerd 123	SUCRALFAT E	TAB 1GM	PO = By Mouth	BID	williams	Taking	Not Taking
atrial fibrillation	MIDODRINE	TAB 10MG	PO = By Mouth	QD		Taking	Not Taking
ibs, gerd	ONDANSETRON	TAB 4MG ODT	PO = By Mouth	TID	williams	Taking	Not Taking
afib	ELIQUIS	TAB 2.5MG	PO = By Mouth	QD		Taking	Not Taking
htn	AMLODIPINE	TAB 10MG	PO = By Mouth	HS	williams	Taking	Not Taking
esrd	SEVELAMER	TAB 800MG	PO = By Mouth	TID		Taking	Not Taking
gerd	PANTOPRAZOLE	TAB 40MG	PO = By Mouth	QAM		Taking	Not Taking
asthma	IPRATROPIUM/ALBUTER	SOL	PO = By Mouth	PRN		Taking	Not Taking
gout	COLCHICINE	TAB 0.6MG	PO = By Mouth	AC		Taking	Not Taking
htn, cad	METOPROLOL TAR	TAB 25MG	PO = By Mouth	BID	williams	Taking	Not Taking
asthma	MONTELUKAST	TAB 10MG	PO = By Mouth	QAM		Taking	Not Taking

asthma	BREO ELLIPTA	INH 200-25	PO = By Mouth	HS		Taking	Not Taking
hyperlipidemia	ATORVASTATIN	TAB 20MG	PO = By Mouth	HS		Taking	Not Taking

### 36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
07-13-2021	tylenol arthritis	500mg	PO = By Mouth	prn
07-13-2021	aspirin	81mg	PO = By Mouth	daily
07-13-2021	zyrtec	10mg	PO = By Mouth	daily

### 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

Comment: needs singulair refilled

## Review of Systems and Diagnoses

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

☒ Yes ☐ No

#### Diagnoses

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

#### Cataracts

#### Describe

☒ Active ☐ History of ☐ Rule out

#### Supported by



- ☒ **History**
- ☐ Medications
- ☐ Biopsy
- ☐ Symptoms
- ☐ Test results
- ☐ DME
- ☐ Physical Findings
- ☐ Image studies
- ☐ Other
- ☐ Secondary to Diabetes
  - ☐ Yes
- ☒ **No**
- Difficulty with vision
  - ☐ Describe
    - ☒ **Active**
  - ☐ Legally Blind
    - ☐ Yes
  - ☐ History of
  - ☐ Rule out
  - ☒ **No**

Do you wear glasses or contacts?

- ☒ **Yes** ☐ No

comments

glasses

☐ Do you have trouble seeing even with glasses?

- ☐ Yes ☒ **No**

Do you have problems seeing at night?

- ☐ Yes ☒ **No**

Do you have eye pain?

- ☐ Yes ☒ **No**

Do you have problems with tearing?

- ☐ Yes ☒ **No**

Do you have a problem with dry eye?

- ☐ Yes ☒ **No**

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

- ☐ Yes ☒ **No**

Nose Problems (Nose Bleeds, Sinus infections, Other)

- ☒ **Yes** ☐ No

☐ Diagnoses

- ☐ Chronic Post Nasal Drip
- ☐ 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

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

☒ Other

Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☐ Symptoms

☒ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Other

comments

enlarged goiter

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

☐ Chronic Cough

☒ Use of Inhaled or oral steroids

☐ Cyanosis

☐ Use of ventilator

☐ Use of Bronchodilator

☐ Other

Is patient on controller medications

☒ Yes

☐ No

Does patient use rescue medications

☒ Yes

☐ No

Does patient have current exacerbation

☐ Yes

☒ No

Use of Oxygen

☐ Yes

☒ No

Shortness of breath

☐ Yes

☒ No

Wheezing

☐ Yes

☒ No

Chronic Cough

☐ Yes

☒ No

Patient requires durable medical equipment

☐ Yes

☒ No

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

☒ Yes

☐ No

↳ 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

Atrial Fibrillation

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Type

☐ Paroxysmal

☒ Chronic

☐ Unknown

↳ Supported by

☒ Medications

☐ History

☒ ECG

☐ Electric cardioversion

☐ Symptoms

☐ Other

↳ Is patient taking

☒ Anticoagulant

☒ Rate controlling medication

☐ Other

Hyperlipidemia

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☐ Lab results

☒ Medication

☐ Other

↳ Is patient on Statin

☒ Yes

☐ No

Hypertension

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☐ Physical Exam

☒ Medications

☐ Symptoms

☐ Other

↳ Adequately controlled

☒ Yes

☐ No

☐ UnKnown

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

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 than 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

☐ Gastroparesis

☒ GERD

☐ Hepatitis

☒ Inflammatory Bowel Disease

☐ Pancreatitis

☐ Ulcer Disease

☐ Other

Gall Bladder Disease

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☒ Symptoms

☐ Passing of stones

☐ ERCP

☐ HIDA Scan  
☐ Other

☐ MRI

☒ **Treatment history**

comments

cholecystectomy

### GERD

↳ Describe

☒ **Active**

☐ History of

☐ Rule out

↳ Supported by

☐ Heartburn /  
Dyspepsia  
☐ Other

☐ Regurgitation

☒ **Medications**

### Inflammatory Bowel Disease

↳ Describe

☒ **Active**

☐ History of

☐ Rule out

↳ Supported by

☐ Colonoscopy  
☒ **Medications**

☐ Symptoms  
☐ Other

☐ Physical Findings

↳ Describe

☐ Ulcerative Colitis

☐ Crohn's Disease

☒ **Other**

comments

chronic constipation

↳ 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**

### 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

comments

with her sister she is ready for her to move out

### 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

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)

comments

not assessed; member states normal with walker use

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

☒ Yes

☐ No

Diagnoses

☐ Acute Renal Failure

☐ BPH

☐ Chronic Kidney Disease

☒ ESRD

☐ Erectile Dysfunction

☐ Frequent UTI

☐ Kidney Stones

☐ Nephritis or Nephrosis

☐ Urinary Incontinence  
ESRD

☐ Other

☐ Describe

☒ Active

☐ History of

☐ Rule out

☐ Supported by

☒ Lab tests

☐ Calculated GFR X 3

☐ Symptoms

☐ Other

☐ Patient on dialysis

☒ Yes

☐ No

☐ On a special diet

☒ Yes

☐ No

History of frequency

☐ Yes

☒ No

History of Nocturia

☐ Yes

☒ No

History of Hesitancy

☐ Yes

☒ No

Do you have trouble urinating?

☒ Yes

☐ No

comments

still makes urine once daily  
dialysis Mon, Wed, Fri

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
- ☐ Osteoporosis

☐ Rheumatoid Arthritis

☐ Systemic Lupus Erythematosus

☒ **Other**

Gout

- ☐ Describe

☐ Active

☒ **History of**

☐ Rule out
- ☐ Supported by

☒ **History of attacks in Foot**

☐ Lab tests

☒ **Medications**
- ☐ Other

Spinal Stenosis

- ☐ Describe

☒ **Active**

☐ History of

☐ Rule out
- ☐ Supported by

☒ **Symptoms**

☐ Physical Findings

☐ Image studies

☐ Medications

☐ Other
- ☐ Normal bladder and bowel function

☒ **Yes**

☐ No

comments

normal for ESRD

Other

- ☐ Describe

☒ **Active**

☐ History of

☐ Rule out
- ☐ Supported by

☒ **History**

☒ **Symptoms**

☐ Physical Findings

☐ Test results

☐ Image studies

☐ Medications

☐ DME

☐ Biopsy

☐ Other
- ☐ Other

comments

Degenerative disc disease, SCI

History / Finding of non- extremity Fracture

- ☐ Yes

☒ **No**

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

Endocrine Problems

☒ Yes ☐ No

↳ Diagnoses

- |   |   |
|---|---|
| <input type="checkbox"/> Chronic Kidney Disease secondary to Diabetes | <input checked="" type="checkbox"/> <b>Coronary Artery Disease and Diabetes</b> |
| <input type="checkbox"/> Cushing's Disease                            | <input checked="" type="checkbox"/> <b>Diabetes</b>                             |
| <input type="checkbox"/> Diabetic Retinopathy                         | <input type="checkbox"/> Secondary Hyperparathyroidism                          |
| <input checked="" type="checkbox"/> <b>Hypertension and Diabetes</b>  | <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  |

**Coronary Artery Disease and Diabetes**

↳ Describe

☒ **Active** ☐ History of ☐ Rule out

↳ Supported by

<input checked="" type="checkbox"/> <b>History</b>	<input checked="" type="checkbox"/> <b>Symptoms</b>	<input 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

↳ Is patient on a statin

☒ **Yes** ☐ No

↳ Is patient on an aspirin

☒ **Yes** ☐ No

**Diabetes**

↳ Describe

☒ **Active** ☐ History of ☐ Rule out

↳ Supported by

<input checked="" type="checkbox"/> <b>Symptoms</b>	<input type="checkbox"/> Physical findings	<input type="checkbox"/> Lab tests
<input type="checkbox"/> Medications	<input type="checkbox"/> Other	

↳ Type

☐ Type 1 ☒ **Type 2** ☐ Gestational

↳ Most recent Hb A1C, value

comments

7.0%

↳ And Date

comments

7/2021

↳ Met with a nurse or dietician for diabetic education

☒ **Yes** ☐ No

↳ Met with a diabetic educator

☒ **Yes** ☐ No

↳ Treatment includes

☒ **Diet**

☐ Oral hypoglycemic agent  
☐ Insulin  
☐ Weight loss

☐ Exercise

## Hypertension and Diabetes

☐ Describe

☒ **Active**

☐ History of

☐ Rule out

☐ Supported by

☒ **History**

☒ **Symptoms**

☐ Physical Findings

☒ **Medications**

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

☐ Is patient on Ace or ARB

☒ **Yes**

☐ No

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

☐ Yes

☒ **No**

Do you often feel thirsty?

☐ Yes

☒ **No**

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

☐ Yes

☒ **No**

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

☐ Yes

☒ **No**

Do you get ulcers on your legs or feet?

☐ Yes

☒ **No**

Do you feel sluggish?

☐ Yes

☒ **No**

Do you sweat a lot or constantly feel hot?

☐ Yes

☒ **No**

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

☒ **Yes**

☐ No

Have you ever had dialysis?

☒ **Yes**

☐ No

comments

ESRD Mon, Wed, Fri

Is your skin itchy?

☐ Yes

☒ **No**

Do you test your blood sugar?

☒ **Yes**

☐ No

comments

member checks BG once weekly on her glucometer machine which is typically < 110mg/dl; she has dialysis on Mon, Wed, Fri which checks her BG then

Have you lost weight in the past 6 months?

☐ None

☐ 5lbs

☐ 10lbs

☐ 15lbs

☒ **More than 15lbs**

☐ 10% of your weight  
(calculated by assessor)

comments

last 18 lbs from December 2020 - February 2021; she has gained 6 lbs back since dc'd home from rehab

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

Anemia

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Lab tests

☐ Symptoms

☒ History of blood transfusion

☐ Other

Etiology

- ☐ Iron deficiency
- ☐ Hemolysis
- ☐ Blood loss
- ☐ Other

- ☐ Pernicious
- ☐ Aplastic
- ☐ Chronic Disease

- ☒ Kidney disease
- ☐ Chemotherapy
- ☐ Folate Deficiency

If yes, Patient on

- ☐ Iron
- ☐ Blood Transfusions

- ☐ B 12
- ☒ Other

☐ Folic Acid

Other

Describe

comments

last blood transfusion March 2021

Easy bruising or abnormal bleeding

☐ Yes

☒ No

Long term anticoagulation use

☒ Yes

☐ No

Describe

- ☒ Aspirin

☐ Coumadin

☐ Thrombin Inhibitors (Pradaxa)
- ☐ Plavix

☐ Factor Xa Inhibitors (Xarelto, Eliquis)

☐ Other

Cancer

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

Pain

### Does the patient experience pain?

☒ Yes ☐ No

### Is the Pain Acute?

☐ Yes ☒ No

### Is the Pain Chronic?

☒ Yes ☐ No

#### Describe

☐ Active

☒ History of

☐ Rule out

#### Where

posterior neck pain (sometimes)  
b/l knees with weather changes

#### Do you take Methadone

☐ Yes ☒ No

#### What drug/s do you take for it

tylenol prn

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

0

### Is the Patient Undergoing Pain Management Planning?

☐ Yes ☒ No

### Was the patient advised regarding the potential for dependence?

☐ Yes ☒ No

### Is there any evidence of Maladaptive Behavior?

#### Tolerance?

☐ Yes ☒ No

#### Withdrawal?

☐ Yes ☒ No

### Increased usage over a longer period that intended?

☐ Yes ☒ No

### Desire or unsuccessful effort to cut down on use?

☐ Yes ☒ No

### Excess time spent in activities to obtain the substance?

☐ Yes ☒ No

### Continued use despite Doctor advice or patient knowledge of habituation?

☐ Yes ☒ No

### Physical or Psychological Problem related to the substance use?

☐ Yes ☒ No

## Vital Signs

### Vital Signs

comments

low HR discussed with member; normal per patient

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
131 (mmHG)	88 (mmHG)	57 (bpm)	19	97.8	98	0

## BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	3 (Inch)	192 (lbs)	34.0

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

## Exam Review

### Constitutional

General appearance:	Normal	Abnormal
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### Head and Face

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

### Eyes

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

### Ears, Nose, Mouth and Throat

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

### Neck

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

Comment: goiter - discussed with member

### Pulmonary

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

Cardiovascular

Palpation of heart:	Normal	Abnormal
Auscultation of heart:	Normal	Abnormal
Comment: bradycardia		
Carotid Arteries:	Normal	Abnormal
Abdominal Aorta:	Normal	Abnormal
Comment: abd soft, nondistended		
Pedal Pulses:	Normal	Abnormal
Examination of Arterial Pulses:	Normal	Abnormal
Comment: PAD testing completed		
Examination of Edema / Varicosities:	Normal	Abnormal

Lymphatic

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

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
Comment: not assessed		
Inspection/palpation of digits and nails:	Normal	Abnormal
Inspection/palpation of joints, bones and muscles:	Normal	Abnormal
Comment: left arm AV fistula gradt		
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: +bruits/thrills lt arm AV fistula

## Neurologic

Indicate specific cranial nerve tested

grossly intact

Indicate cranial nerve deficits found

na

Romberg Test	Normal	Abnormal
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Comment: deferred

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

## Diabetes

Foot Exam:	Normal	Abnormal
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## Psychiatric

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

## Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnoses	Comments
DIGITAL_RETINAL_EXAM	Yes	Completed Kit with Member			Yes	07-13-2021	L: No diabetic Retinopathy R: No diabetic Retinopathy	Type 2 diabetes mellitus	
HBA1C	No	Completed Kit with Member	77000606	77000606	Yes	07-13-2021			
MICROALBUMIN	No	Refused Kit			No	07-13-2021	screening not done today; patient only makes urine once daily	ESRD; CKD	



FOBT	Yes	Refused Kit			Select				
DEXA	No	Select			Select				
PAD	Yes	Completed Kit with Member			Yes	07-13-2021	Rt foot =1.04 Lt foot=0.94	diabetes mellitus type 2; CKD	
LDL	N/A	Select			Select				

Mini-Cog

### 39. Mini- Cog (see attached sheet)

#### Step 1: Three Word Registration

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

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

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

#### Step 2: Clock Drawing

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

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

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

#### Step 3: Three Word Recall

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

Word List Version : 3

Person's Answers: village, baby

Word Recall :	2 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 :	4 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	Yes	No
--	-----	----

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?**  
unable to obtain

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

**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 :

72yo female lives in her home with her sister; she receives HHA services 5 days/ week and every other Saturday. She had SCI in December 2020 requiring emergent back surgery which she had 3 compressed discs and she is doing wonderful now. She has suffered with chronic lumbar back pain "for years," but after her surgery, she is doing a lot better. She uses a walker to ambulate and has 3 steps on her backporch that she is afraid of, but when her HHA helps her, she is comfortable. Preventative care discussed with member, she verbalizes understanding.

### 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 :	2021-07-13T14:28
Time exam finished	2021-07-13T15:45
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Provider Signature	<div><div>Digitally signed by Brittney Walls, FNP 2021-07-21, 08:56</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?