

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	DARYL JORDAN
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1947-02-01
Evaluation Date :	2021-7-18 12:30 PM
Visit Type :	

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICARE
LOB	DSNP
Name	DARYL JORDAN
Gender	Male
Address	211 MARCELLA ROAD
City	HAMPTON
State	VA
Zip	23601-3102
Date of Birth	1947-02-01
Age(as of date)	74
Marital Status	Divorced
Member Identification Number	11007387
HICN	1JV9EX9QQ56
Phone Number	7572689921
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	Eunice Peele
Phone Number	757-717-6851
Primary Care Physician	Dr. Bailey
Phone Number	
PCP Address	
PCP City	
PCP State	VA

PCP Zip	
PCP County	
Office ID	
Office Name	

1. Race

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

2. Preferred language

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

knows neighbors, ex wife helps him when she can

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

14. Alcohol Use

☐ Current

☒ Former

☐ Never

How many drinks	How Often
4	Day

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

☒ Yes

☐ No

↳ Which drugs or medication
former- meth, heroin, cocaine

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

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

A. Seen your PCP	None	1	2	3	4	5 or more
B. Visited the Emergency Room	None	1	2	3	4	5 or more
C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
D. Been in a nursing home	None	1	2	3	4	5 or more
E. Had Surgery	None	1	2	3	4	5 or more

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

- ☐ Yes
 ☒ No

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

Physical Therapist	Yes	No
Occupational Therapist	Yes	No
Dietician	Yes	No
Social Worker	Yes	No
Pharmacist	Yes	No
Speech Therapist	Yes	No
Chiropractor	Yes	No
Personal Care Worker (HHA, CNA, PCA)	Yes	No
Meals on Wheels	Yes	No

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

Chemotherapy	Yes	No	Unknown
Catheter Care	Yes	No	Unknown
Oxygen	Yes	No	Unknown
Wound Care	Yes	No	Unknown
Regular Injections	Yes	No	Unknown
Tube Feedings	Yes	No	Unknown

Family History

26. Family History

☒ Yes

☐ No

Family Member	Medical Condition	Cause of Death
Other	alzheimers	unknown
Father	legally blind	unknown
Mother	alcoholic	MI

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	No
Prostate Exam/PSA	Yes
If Diabetic Eye Exam	Not Applicable
If Diabetic Foot Exam	Not Applicable
If Diabetic Hgb A1c screen	Not Applicable
Lipid Panel	Yes

28. Last colonoscopy if more than 2 years ago

☐ 3 – 5 years ago

☐ 6 – 10 years ago

☐ > 10 years ago

☐ Never

☐ Don't know

29. Screen for abnormal glucose / diabetes - age 40 - 70

☒ Yes

☐ No

☐ NA

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

☐ Yes

☐ No

☐ NA

comments

not sure

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

☐ Yes

☐ No

☐ NA

comments

not sure

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	
	SIMVASTATIN	TAB 20MG	Select	Select		Taking	Not Taking
	AMLODIPINE	TAB 10MG	Select	Select		Taking	Not Taking
	FUROSEMIDE	TAB 20MG	Select	Select		Taking	Not Taking
TIA/stroke	CLOPIDOGREL	TAB 75MG	PO = By Mouth	QD	pcp	Taking	Not Taking
HTN	prinivil	10mg	PO = By Mouth	QD	pcp	Taking	Not Taking
hyperlipidemia	fish oil	1000mg	PO = By Mouth	QD	pcp	Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ Yes

☐ No

Date	Description	Dose/Units	Route	Frequency
07-18-2021	probiotic	2 capsules	PO = By Mouth	daily
07-18-2021	prostate health	2 soft gels	PO = By Mouth	BID
07-18-2021	vitamin c	1000mg	PO = By Mouth	daily
07-18-2021	centrum silver	1 tablet	PO = By Mouth	daily
07-18-2021	vitamin d	1000 IU	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

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

Difficulty with vision

Describe

☒ Active

☐ History of

☐ Rule out

Legally Blind

☐ Yes

☒ No

Do you wear glasses or contacts?

☒ Yes ☐ No

comments

reading

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

loss of taste/smell- last 20 years

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

☒ **Yes** ☐ **No**

Diagnoses

- ☐ Bleeding Gums
- ☐ Difficulty Swallowing
- ☒ **Difficulty Chewing**
- ☐ Other

Describe

☒ **Active** ☐ History of ☐ Rule out

comments

missing teeth

Because of pain

☐ **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

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

Cardiomyopathy

Describe

☒ **Active** ☐ History of ☐ Rule out

Supported by

☐ Echo ☐ Cardiac Cath ☐ Other

comments

could not describe test done

Secondary to Hypertension

☒ **yes**

☐ No

Hyperlipidemia

☐ Describe

☒ **Active**

☐ History of

☐ Rule out

☐ Supported by

☒ **Lab results**

☐ Medication

☐ Other

☐ Is patient on Statin

☐ Yes

☒ No

comments

fish oil, hx of muscle/leg cramps

Hypertension

☐ Describe

☒ **Active**

☐ History of

☐ Rule out

☐ Supported by

☐ Physical Exam

☒ Medications

☐ Symptoms

☐ Other

☐ UnKnown

☐ Adequately controlled

☒ **Yes**

☐ No

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

☐ Gall Bladder Disease

☒ GERD

☐ Inflammatory Bowel Disease

☐ Ulcer Disease
- ☐ Diverticulitis

☐ Gastroparesis

☐ Hepatitis

☐ Pancreatitis

☐ Other

GERD

Describe

- ☐ Active

Supported by

- ☒ Heartburn /
Dyspepsia
- ☐ Other

☒ History of

- ☐ Regurgitation

- ☐ Rule out

- ☐ Medications

History of blood in stool

- ☐ Yes
- ☒ No

History of black stools

- ☐ Yes
- ☒ No

History of Heartburn / Dyspepsia

- ☒ Yes
- ☐ No

Describe

- ☒ Occasionally
- ☐ Chronic

comments

does not require treatment at this time

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

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Alcohol Dependence | <input type="checkbox"/> Amyotrophic Lateral Sclerosis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Cerebral Hemorrhage |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Delusional Disease |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Drug Dependence | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Generalized Anxiety Disorder | <input type="checkbox"/> Guillain-Barre Disease |
| <input type="checkbox"/> Hemiparesis | <input type="checkbox"/> Huntington's Chorea |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Intellectual and or Developmental Disability |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Restless leg syndrome | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Spinal Cord Injury |
| <input checked="" type="checkbox"/> Stroke | <input type="checkbox"/> Subdural Hematoma |
| <input checked="" type="checkbox"/> TIA | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Other | |

Stroke

Describe

☒ **Active** ☐ History of ☐ Rule out

Supported by

☐ Hospitalization ☐ Image study ☒ **Physical findings**
☐ Sensory findings ☐ Other

Physical findings

Physical findings

<input type="checkbox"/> None	<input type="checkbox"/> Right arm paralysis	<input checked="" type="checkbox"/> Left arm paralysis
<input type="checkbox"/> Right leg paralysis	<input checked="" type="checkbox"/> Left leg paralysis	<input type="checkbox"/> Right hemiparesis
<input checked="" type="checkbox"/> Left hemiparesis	<input type="checkbox"/> Aphasia	<input type="checkbox"/> Apraxia
<input type="checkbox"/> Cranial nerve paralysis	<input type="checkbox"/> Functional Quadriplegia	

TIA

Describe

☐ Active ☒ **History of** ☐ Rule out

Supported by

☒ **History** ☐ Physical exam ☐ Image studies
☐ 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 trouble understanding what people say to you?

☐ Yes☒ No

Do your hands shake?

☐ Yes☒ No

Do you have convulsions and seizures?

☐ Yes☒ No

Do you have trouble with your memory?

☐ Yes☒ No

Do you have trouble finding words?

☐ Yes☒ No

Do you have trouble sleeping?

☐ Yes☒ No

Have you lost your appetite

☐ Yes☒ No

Do you hear voices or see things that other people do not

☐ Yes☒ No

Do you have highs and lows

☐ Yes☒ No

Do you ever feel like someone is out to get you

☐ Yes☒ No

How often do you go out to meet with family or friends

☐ Often☒ Sometimes☐ Never

GPCOG Score or MMSE Score

GPCOG Score	or MMSE Score

If GPCOG or MMSE is not done, is

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

Affect

- ☒ Normal ☐ Abnormal

Over the past 2 weeks, how often have you been bothered by any of the following problems?

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

PHQ 2 Score

- ☒ < 3 ☐ 3 or more

Speech

- ☒ Normal ☐ Slurred ☐ Aphasic
- ☐ Apraxia

Finger to Nose

- ☐ Normal ☒ Abnormal
- ☒ If abnormal
 - ☒ Left ☐ Right ☐ Both

Heel (Shin) to Toe

- ☐ Normal ☒ Abnormal
- ☒ If abnormal
 - ☒ Left ☐ Right ☐ Both

Thumb to Finger Tips

- ☐ Normal ☒ Abnormal
- ☒ If abnormal
 - ☒ Left ☐ Right ☐ Both

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

Diagnoses

☐ Acute Renal Failure

☐ Chronic Kidney Disease

☐ Erectile Dysfunction

☐ Kidney Stones

☐ Urinary Incontinence

☒ BPH

☐ ESRD

☐ Frequent UTI

☐ Nephritis or Nephrosis

☐ Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Physical exam

☒ Symptoms

☐ Lab test

☐ Biopsy

☒ Medication

☐ Hospitalization

☐ Other

History of frequency

☒ Yes

☐ No

☐ 3x / day

☒ 4x / day

☐ 5x / day

☐ >5x / day

History of Nocturia

☐ Yes

☒ No

History of Hesitancy

☐ Yes

☒ No

Do you have trouble urinating?

☐ Yes

☒ No

Do you ever have blood in your urine?

☐ Yes

☒ No

Do you have any weakness or deformity in your arms or legs that limits your ability to get around or do what you want to do?

☐ Yes

☒ No

Do you have trouble holding your urine?

☐ Yes

☒ No

Do you trouble getting to the bathroom on time?

☐ Yes

☒ No

Do you ever have pain or burning during urination?

☐ Yes

☒ No

Do you ever wear pads or diapers?

☐ Yes

☒ No

Do you have a vaginal discharge?

☐ Yes

☒ No

Do you have vaginal bleeding?

☐ Yes

☒ No

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

☒ Yes

☐ No

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

Osteoarthritis

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Symptoms

☐ Physical Findings

☐ Image studies

☐ Other

Which joints

comments

right wrist

Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☒ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☒ DME

☐ Other

Other

comments

lower leg swelling, cramps that are worse at night, wears compression socks.

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

comments

bilateral lower extremities, leg cramps

☒ 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

- Diagnoses
- ☐ AIDS

☐ C. Difficile

☐ HIV

☐ Hospital Acquired MRSA Infection

☐ Leukemia

☐ Multiple Myeloma

☐ Sickle Cell Disease

☐ Thalassemia

☐ Tuberculosis

☐ Other

Vitamin D Deficiency

☐ Anemia

☐ Community Acquired MRSA Infection

☐ Herpes Zoster

☐ Immune Deficiency

☐ Lymphoma

☐ Sepsis

☐ Sickle Cell Trait

☐ Thrombocytopenia

☒ Vitamin D Deficiency

☒ Describe
☒ **Active**

☐ History of
 ☐ Rule out

☒ Supported by
☐ Labs
 ☒ **Medications**
☐ History

☐ Other

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

comments

right wrist- this is his strong arm that he uses for pulling up out of the wheelchair.

Is the Pain Chronic?

☐ Yes
 ☒ **No**

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

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
130 (mmHG)	78 (mmHG)	80 (bpm)	16	98.1	97	1/10

BMI

Patients Height		Patients Weight	Calculate BMI
6 (Feet)	(Inch)	178 (lbs)	24.1

- ☐ 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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Comment: left arm paralysis- minimal movement

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

Comment: missing teeth

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

Comment: 2+ bilateral lower extremities

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: difficulty ambulating, minimal movement in left arm. Left leg can bare some weight

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

Skin

Inspection of skin and subcutaneous tissue:	Normal	Abnormal
Palpation of skin and subcutaneous tissue:	Normal	Abnormal

Neurologic

Indicate specific cranial nerve tested

able to smile, stick out tongue, puff cheeks, shrug shoulders, move head/eyes side to side and up/down

Indicate cranial nerve deficits found

n/a

Romberg Test	Normal	Abnormal
Comment: unable to perform		
Examination of reflexes:	Normal	Abnormal
Comment: left arm no response, right arm normal 2+, Left and right legs 1+		
Examination of sensation:	Normal	Abnormal
Coordination:	Normal	Abnormal
Comment: difficulty with left arm and left leg		

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	No	Select			No				
HBA1C	No	Select			No				
MICROALBUMIN	No	Select			No				
FOBT	Yes	Select			Member Refused				
DEXA	No	Select			No				
PAD	No	Select			No				
LDL	N/A	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, sunrise, chair

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

Home Safety & Personal Goals

40. In the past year how many times have you Fallen?

- ☒ None
- ☐ Once
- ☐ Twice
- ☐ Three times
- ☐ More than three times

41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?	Yes	No
b. Do you have electrical cords running across floors, in doorways or under a rugs?	Yes	No
c. Do you have no slip mats on the shower floor or bath tub?	Yes	No
d. Do have adequate lighting in hallways and on the stairs?	Yes	No
e. Do you have handrails on staircases?	Yes	No
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	Yes	No

all sleeping a rooms?		
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?

" more mobility"

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

" be more active, carpet changed"

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 :

After confirmation of patient's name and DOB a face to face appointment was performed. The patient did not endorse vitamin B deficiency, hematuria, or neuropathic bladder. He answered questions appropriately and was interactive during appointment. He does express frustration that the apartment complex has not changed the carpet in his apartment for some time. He reports he is doing his best to keep it clean. He would like a referral for a dentist and home health aide so he can receive help with ADLs, mainly cleaning and assistance with bathing, as his usual support person where he lives is not able to help him anymore.

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 :	2021-07-18T12:00
Time exam finished	2021-07-18T13:00
I accept the Disclosure Statement	<input checked="" type="checkbox"/>

Preventative Care checklist reviewed and left with member	<input type="checkbox"/>
Provider Signature	<div><div>Lindsay M Otis, FI</div><div>Digitally signed by Lindsay Otis, NP 2021-07-22, 17:55</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?