

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	WENDY MITCHELL
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1962-08-20
Evaluation Date :	2021-7-26 02:00 PM
Visit Type :	In Person

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICARE
LOB	DSNP
Name	WENDY MITCHELL
Gender	Female
Address	211 PARSON STREET
City	DANVILLE
State	VA
Zip	24541-4160
Date of Birth	1962-08-20
Age(as of date)	58
Marital Status	Widowed
Member Identification Number	11007760
HICN	8H72CG2YW22
Phone Number	3364977647
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	Breanna Cooper
Phone Number	3364236776
Primary Care Physician	Olinger, August
Phone Number	
PCP Address	
PCP City	Danville
PCP State	VA

PCP Zip	
PCP County	
Office ID	
Office Name	Sova Internal Medicine

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**

daughter lives nearby, will come check on her weekly

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**

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

comments

discussed the importance of completing.

Within the past 12 months we worried whether our food would run out before we got money to buy more. Was that _____ for your household?

☐ Often True
 ☐ Sometimes True
 ☒ **Never True**

Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Was that _____ for your household?

☐ Often True
 ☐ Sometimes True
 ☒ **Never True**

Activities of Daily Living

19. Do you have any difficulty with the following activities?

A. Getting in or out of bed	No	Need Some Help	Need Total Help
B. Getting in or out of chairs	No	Need Some Help	Need Total Help
C. Toileting	No	Need Some Help	Need Total Help
D. Bathing	No	Need Some Help	Need Total Help
E. Dressing	No	Need Some Help	Need Total Help
F. Eating	No	Need Some Help	Need Total Help
G. Walking	No	Need Some Help	Need Total Help
H. Going up or down stairs	No	Need Some Help	Need Total Help

Medical History

20. Do you use any assistive devices? (Check device or none if no devices used)

☐ None
 ☒ **Cane**
☒ **Walker**
☐ Prosthesis

☒ **Wheel Chair**
☐ Bedside Commode
 ☐ Urinal

☐ Bed Pan
 ☐ Other

21. Are you currently seeing any specialists?

☒ **Yes**
☐ No

Medical Specialty	Specialist	For
Gastroenterologist	Dr. Candia	hiatal hernia, colon ca
Other	Dr Hartline- danville dental	being fitted for dentures
Ophthalmologist	Dr. Chin	DM eye exam
Psychiatrist	Dr. Denunzio	PTSD, bipolar

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](#)

end of march/early april - severe dehydration

C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
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[If one or more, describe](#)

for ankle surgery

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](#)

March 19, 2021 left ankle fusion

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

☒ Yes ☐ No

[Describe](#)

for ankle surgery

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
Mother	bipolar	drug addiction
Sibling1	bipolar	drug addiction
Father	DM, alzheimers	unknown
Other	colon ca	colon ca

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	Yes
Breast Exam/Mammography	Yes
Cervical Screening	Yes
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

comments

Less than 3 years ago

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

↳ Zostervax

☐ Yes
 ☐ No
 ☒ Unknown

↳ Shingrex

☐ Yes
 ☐ No
 ☒ Unknown

Allergies / Medications

35. Allergies

☒ Yes
 ☐ No

Substance	Reaction
PCN	anaphylaxis

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
	OXYCODONE	TAB 5MG	Select	Select		Taking	Not Taking
DM	METFORMIN	TAB 1000MG ER	PO = By Mouth	BID	PCP	Taking	Not Taking
DM	JARDIANCE	TAB 10MG	PO = By Mouth	QD	PCP	Taking	Not Taking
bipolar/ anxiety	ESCITALOPRAM	TAB 10MG	PO = By Mouth	QD	PCP	Taking	Not Taking
	PIOGLITAZONE	TAB 15MG	Select	Select		Taking	Not Taking
bipolar/ anxiety	QUETIAPINE	TAB 25MG	PO = By Mouth	TID	PCP	Taking	Not Taking
HTN	LISINOPRIL	TAB 10MG	PO = By Mouth	QD	PCP	Taking	Not Taking
hyperlipidemia	ATORVASTATIN	TAB 40MG	PO = By Mouth	HS	PCP	Taking	Not Taking

anxiety	HYDROXYZ PAM	CAP 25MG	PO = By Mouth	PRN	PCP	Taking	Not Taking
	BACLOFEN	TAB 10MG	Select	Select		Taking	Not Taking
DM	TRULICITY	INJ 1.5/0.5	SQ = Subcutaneous	QW	PCP	Taking	Not Taking
bipolar/ anxiety	BUSPIRONE	TAB 30MG	PO = By Mouth	BID	PCP	Taking	Not Taking
sleep	TRAZODONE	TAB 150MG	PO = By Mouth	HS	PCP	Taking	Not Taking
	TRAMADL/ APAP	TAB 37.5-325	Select	Select		Taking	Not Taking
	PROMETHAZINE	TAB 25MG	Select	Select		Taking	Not Taking
	AZITHROMYCIN	TAB 250MG	Select	Select		Taking	Not Taking
	CLINDAMYCIN	CAP 150MG	Select	Select		Taking	Not Taking
	NARCAN	SPR	Select	Select		Taking	Not Taking
	ENULOSE	SOL 10GM/15	Select	Select		Taking	Not Taking
	NITROFURANTIN	CAP 100MG	Select	Select		Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ Yes
☐ No

Date	Description	Dose/Units	Route	Frequency
07-26-2021	womens multivitamin	1 tablet	PO = By Mouth	daily
07-26-2021	ASA	650mg	PO = By Mouth	BID
07-26-2021	glucosamine	2 tabs	PO = By Mouth	daily
07-26-2021	krill oil	2 tabs	PO = By Mouth	daily
07-19-2021	tylenol	650mg	PO = By Mouth	PRN

comments

Naproxen 1-2 tablets PO PRN pain, colace 1 capsule PRN constipation

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

Cataracts

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ History

☐ Medications

☐ Biopsy

☒ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

comments

bilateral

Secondary to Diabetes

☒ Yes

☐ No

Difficulty with vision

Describe

☒ Active

☐ History of

☐ Rule out

Legally Blind

☐ Yes

☒ No

Do you wear glasses or contacts?

☒ Yes

☐ No

comments

for 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

Diagnoses

☒ Difficulty with Hearing

☐ Legally Deaf

☐ Tinnitus ☒ Vertigo

☐ Other

Difficulty with Hearing

↳ Describe

☒ Active ☐ History of ☐ Rule out

comments reports minimal- does not wear hearing aids

Vertigo

↳ Describe

☒ Active ☐ History of ☐ Rule out

↳ Supported by

☒ History ☐ Symptoms ☐ Physical Findings

☐ Medications ☐ Test results ☐ Image studies

☐ Biopsy ☐ DME ☐ Other

↳ Do you lose your balance

☒ Yes ☐ No

comments possible syncopal episode a couple months ago, is due to discuss with PCP 8/6.

Do you have trouble hearing when people talk to you?

☒ Yes ☐ No

comments not usually

Do you wear a hearing aid?

☐ Yes ☒ No

Do you read lips?

☐ Yes ☒ No

Do you have ear pain or drainage?

☐ Yes ☒ No

Do you ever get dizzy?

☒ Yes ☐ No

↳ Does the room spin?

☒ Yes ☐ No

↳ Do you ever lose your balance?

☒ Yes ☐ No

Nose Problems (Nose Bleeds, Sinus infections, Other)

☐ Yes ☒ No

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

☒ Yes ☐ No

↳ Diagnoses

☐ Bleeding Gums ☒ Difficulty Chewing

☐ Difficulty Swallowing ☐ Other

Difficulty Chewing

↳ Describe

☒ Active ☐ History of ☐ Rule out

↳ Because of pain

☐ Yes ☒ No

comments missing teeth- being fitted for dentures

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

Sleep Apnea

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Use of CPAP

☒ Positive sleep studies

☐ History of sleepiness during the day

☐ Heavy snoring / restlessness during sleep

☐ Other

comments

with weight loss her AHI score has improved, does not require use of CPAP per her report

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 /
- ☐ Aneurysm

☐ Atrial Fibrillation

☐ Cardiomyopathy

Shock

☐ Congestive Heart Failure

☒ **Hyperlipidemia**

☐ Ischemic Heart Disease (CAD)

☐ Peripheral Vascular Disease

☐ Valvular Disease

☐ Deep Vein Thrombosis

☒ **Hypertension**

☐ Myocardial Infarction

☐ Pulmonary Hypertension

☒ **Other**

Hyperlipidemia

Describe

☒ **Active**

Supported by

☒ **Lab results**

Is patient on Statin

☒ **Yes**

History of

☒ **Medication**

☐ Rule out

☐ Other

No

Hypertension

Describe

☒ **Active**

Supported by

☐ Physical Exam

☐ Other

Adequately controlled

☒ **Yes**

History of

☒ **Medications**

☐ Rule out

☐ Symptoms

No

☐ UnKnown

Other

Describe

☒ **Active**

Supported by

☒ **History**

☐ Medications

☐ Biopsy

Other

History of

☐ Symptoms

☐ Test results

☐ DME

Rule out

☐ Physical Findings

☒ **Image studies**

☐ Other

comments

cardiomegaly

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

comments

left ankle

Do you follow a special diet?

☐ Yes

☒ No

Do you have headaches?

☐ Yes

☒ No

Do you feel light headed when you stand up?

☐ Yes

☒ No

Gastrointestinal Problems (Ulcer, Reflux, Hiatal Hernia, Colitis, Other)

☒ Yes

☐ No

Diagnoses

- ☐ Bowel Obstruction

☐ Celiac Disease

☐ Colon Polyps

☐ Gall Bladder Disease

☒ GERD

☐ Inflammatory Bowel Disease

☐ Ulcer Disease
- ☐ Cachexia

☐ Cirrhosis

☐ Diverticulitis

☐ Gastroparesis

☐ Hepatitis

☐ Pancreatitis

☒ Other

GERD

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Heartburn /
Dyspepsia

☐ Regurgitation

☐ Medications

☐ Other

Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☐ Symptoms

☐ Physical Findings

☐ Medications

☒ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Other

comments

hiatal hernia, fatty liver

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

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

☐ Amyotrophic Lateral Sclerosis☐ Cerebral Hemorrhage☐ Delusional Disease☐ Depression☐ Fibromyalgia☐ Guillain-Barre Disease☐ Huntington's Chorea☐ Intellectual and or Developmental Disability☐ Multiple Sclerosis

 FOCUSCARE

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- ☐ Muscular Dystrophy

☐ Parkinson’s disease

☐ Restless leg syndrome

☐ Seizure Disorder

☐ Stroke

☐ TIA
- ☐ Myasthenia Gravis

☐ Peripheral Neuropathy

☐ Schizophrenia

☐ Spinal Cord Injury

☐ Subdural Hematoma

☐ Traumatic Brain Injury

☒ Other

Bipolar Disorder

Describe

- ☒ Active

☐ History of

☐ Rule out

Supported by

- ☐ History of mood swings

☒ Medication

☐ Other

Generalized Anxiety Disorder

Describe

- ☒ Active

☐ History of

☐ Rule out

Supported by

- ☒ Symptoms

☐ GAD 7

☒ Antianxiety medication

☐ Other

Other

Describe

- ☒ Active

☐ History of

☐ Rule out

Supported by

- ☒ History

☒ Medications

☐ Biopsy

☐ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

Other

comments

PTSD

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

comments

with activity

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	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

☐ Apraxia

☐ Slurred

☐ Aphasic

Finger to Nose

☒ Normal

☐ Abnormal

Heel (Shin) to Toe

☒ Normal

☐ Abnormal

Thumb to Finger Tips

☒ Normal

☐ Abnormal

Sitting to Standing

☒ Normal

☐ Needs Assistance

☐ Unable

Facial / Extremity Movement

☐ Motor Tic

☐ Intention Tremor

☐ Spasticity

☒ Normal

☐ Vocal Tic

☐ Non-Intention (Pill rolling) Tremor

☐ Chorea Movement

☐ Benign (Essential Tremor)

☐ Rigidity

☐ Cog wheeling

Gait

☐ Normal

☐ Abductor lurch

☐ Ataxic

☒ Limp

☐ Paretic

☐ Other (Findings may also apply to Musculoskeletal diagnoses)

☐ Wide based

☐ Shuffling

comments

left ankle- surgery a few months ago

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**

Urinary Incontinence

Describe

☒ **Active**

Supported by

- ☐ History
- ☐ Medications
- ☐ Biopsy

Related to stress

☒ **Yes**

Related to

☒ **Dribbling**

Describe

☒ **Daily**

☐ History of

- ☒ **Symptoms**
- ☐ Test results
- ☐ DME

☐ No

☐ Urgency

☐ Few times a week

☐ Rule out

- ☐ Physical Findings
- ☐ Image studies
- ☐ Other

☐ Other

☐ Less than once a week

Other

Describe

☒ **Active**

Supported by

- ☒ **History**
- ☐ Medications
- ☐ Biopsy

☐ History of

- ☒ **Symptoms**
- ☐ Test results
- ☐ DME

☐ Rule out

- ☐ Physical Findings
- ☐ Image studies
- ☐ Other

Other

comments

denies prolapsed bladder/uterus, reports she has a "tilted bladder"

History of frequency

☐ Yes ☒ **No**

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
- ☐ Extremity Fracture (other than Hip)
- ☐ Hallux Valgus
- ☐ Onychomycosis
- ☐ Osteomyelitis
- ☐ Pyogenic Arthritis
- ☐ Spinal Stenosis
- ☐ Tinea Pedis
- ☐ Degenerative Disc Disease
- ☐ Gout
- ☐ Hammer Toes
- ☒ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Systemic Lupus Erythematosus
- ☐ Other

Osteoarthritis

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Symptoms

☐ Physical Findings

☐ Image studies

☐ Other

Which joints

comments

left ankle-- hx of fractured left ankle, multiple surgeries, fusion most recently

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

left ankle

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

comments

left ankle

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

☒ Chronic Kidney Disease secondary to Diabetes

☐ Cushing's Disease

☐ Diabetic Retinopathy

☐ Hypertension and Diabetes

☐ Hypothyroidism

☐ Peripheral Neuropathy secondary to Diabetes

☐ Hyperparathyroidism

☐ Coronary Artery Disease and Diabetes

☒ Diabetes

☐ Secondary Hyperparathyroidism

☐ Hyperthyroidism

☐ Kidney Stone

☐ Peripheral Vascular Disease secondary to Diabetes

☐ Other

Chronic Kidney Disease secondary to Diabetes

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☐ Decreased GFR

☐ Albuminuria

☐ Elevated BUN/
Creatinine

☐ Dialysis

☒ Other

Other

↳ Describe

comments

stage 3 kidney disease

↳ Patient on ACE or ARB

☒ Yes

☐ No

Diabetes

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☐ Symptoms

☐ Physical findings

☒ Lab tests

☒ Medications

☐ Other

↳ Type

☐ Type 1

☒ Type 2

☐ Gestational

↳ Most recent Hb A1C, value

comments

6.4

↳ And Date

comments

Jan 2021

↳ Met with a nurse or dietician for diabetic education

☐ Yes

☒ No

↳ Met with a diabetic educator

☐ Yes☒ No

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

☐ Yes☒ No

Do you often feel thirsty?

☐ Yes☒ No

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

☐ Yes☒ No

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

☐ Yes☒ No

Do you get ulcers on your legs or feet?

☐ Yes☒ No

Do you feel sluggish?

☐ Yes☒ No

Do you sweat a lot or constantly feel hot?

☐ Yes☒ No

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

☐ Yes☒ No

Have you ever had dialysis?

☐ Yes☒ No

Is your skin itchy?

☐ Yes☒ No

Do you test your blood sugar?

☐ Yes☒ No

comments

Does not check because A1C has been better. Reports when blood work is done it is typically in the 120s.

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

☐ Anemia☒ Community Acquired MRSA Infection☐ Herpes Zoster☐ Immune Deficiency☐ Lymphoma☐ Sepsis☐ Sickle Cell Trait☐ Thrombocytopenia☐ Vitamin D Deficiency

Community Acquired MRSA Infection

Describe

Active

History of

Rule out

Supported by

Cultures

Hospitalization

Medications

Physical findings

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

Describe

Active

History of

Rule out

Supported by

Physical findings

Hospitalization

Treatments

Lab tests

Imaging studies

Surgery

Biopsy

Other

Type

Brain

Head

Neck

Breast

Lung

Esophagus

Stomach

Liver

Pancreas

Colon

Rectum

Kidney

Bladder

Ovaries

Uterus

Prostate

Bone

Blood

Lymph Nodes

Skin

Other

Specific type/s

colon

Stage or Classification specific to the cancer

in remission- no chemo/radiation

Active treatment

Yes

No

History / Finding of Metastasis

Yes

No

Do you see a specialist?

Yes

No

Provider

Dr. Pandya

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

left ankle

↳ Do you take Methadone

☐ Yes ☒ No

↳ What drug/s do you take for it

Naproxen/tylenol

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

6.5/10

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
(mmHG)	(mmHG)	(bpm)	14			65/10

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	3 (Inch)	260 (lbs)	46.1

- ☐ 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

Comment: unable to perform, virtual visit

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

Comment: unable to perform, virtual visit

Assessment of hearing:	Normal	Abnormal
Inspection of nasal mucosa, septum and trubينات:	Normal	Abnormal

Comment: unable to perform, virtual visit

Inspection of lips, teeth and gums:	Normal	Abnormal
-------------------------------------	--------	----------

Comment: missing multiple teeth

Examination of oropharynx:	Normal	Abnormal
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Neck

Examination of neck:	Normal	Abnormal
Examination of thyroid:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
Percussion of chest:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Palpation of chest:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Auscultation of lungs:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Cardiovascular

Palpation of heart:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Auscultation of heart:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Carotid Arteries:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Abdominal Aorta:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Pedal Pulses:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Examination of Arterial Pulses:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Examination of Edema / Varicosities:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Lymphatic

Palpation of cervical nodes (neck)	Normal	Abnormal
Comment: unable to perform, virtual visit		
Palpation of preauricular nodes (in front of the ears)	Normal	Abnormal
Comment: unable to perform, virtual visit		

Palpation of Submandibular nodes (under jaw line/chin)	Normal	Abnormal
Comment: unable to perform, virtual visit		

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
Comment: slight limp, left ankle		
Inspection/palpation of digits and nails:	Normal	Abnormal
Comment: unable to palpate		
Inspection/palpation of joints, bones and muscles:	Normal	Abnormal
Comment: unable to palpate		
Assessment of range of motion:	Normal	Abnormal
Comment: decreased left ankle		
Assessment of stability:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Assessment of muscle strength/tone:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Skin

Inspection of skin and subcutaneous tissue:	Normal	Abnormal
Palpation of skin and subcutaneous tissue:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Neurologic

Indicate specific cranial nerve tested

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

Indicate cranial nerve deficits found

n/a

Romberg Test	Normal	Abnormal
Comment: unable to perform, virtual visit		
Examination of reflexes:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Examination of sensation:	Normal	Abnormal
Comment: unable to perform, virtual visit		

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	Yes	Select			No				
HBA1C	Yes	Select			No				
MICROALBUMIN	Yes	Select			No				
FOBT	Yes	Select			Yes	01-20-2021	Negative		
DEXA	N/A	Select			No				
PAD	Yes	Select			No				
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, 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

comments

She endorses a fall related to dizziness/ possible syncopal episode. She reports she is going to discuss with her PCP at her upcoming appt, I have instructed her to call 911 if she feels like one of these episodes is coming on.

- ☐ 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
- ☐ 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
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?

" I would like to be pain free so I can do what I would like to"

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

" not really, it's not a bad quality now"

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

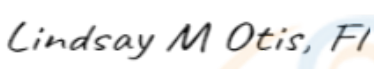
Patient Summary

Assessors Comments :

After confirmation of patient's name and DOB a virtual visit was performed. Information was provided by the patient. The patient was pleasant and appropriate during the visit and answered all questions. Part of the physical exam including auscultation and palpation were not able to be assessed due to the nature of a virtual visit. Inspection and direct visualization were utilized to assess appearance/normal variance. All questions were answered and they understand further communication will be provided by focus care if there are any additional questions or concerns. Please note that during the exam the patient denies borderline personality disorder and prolapsed bladder/uterus.

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 :	2021-07-26T14:00
Time exam finished	2021-07-26T14:54
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input checked="" type="checkbox"/>
Preventative Care checklist reviewed and left with member	<input type="checkbox"/>
Provider Signature	<div>  <div> Digitally signed by Lindsay Otis, NP 2021-07-28, 10:53 </div> </div>

Addendum	
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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?