

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	KELLY S EPPARD
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1971-12-09
Evaluation Date :	2021-7-10 03:00 PM
Visit Type :	

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	Medicare
LOB	DSNP
Name	KELLY S EPPARD
Gender	Male
Address	1150 NORTHWEST DRIVE
City	CHARLOTTESVLE
State	VA
Zip	229019999
Date of Birth	1971-12-09
Age(as of date)	49
Marital Status	Single
Member Identification Number	11011183
HICN	6YN5T24TW86
Phone Number	4349628380
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	Betty Eppard
Phone Number	4349628380
Primary Care Physician	ASAORAGOSTA, KIYOKO
Phone Number	4349731831
PCP Address	3025 Berkmar Dr Ste 1
PCP City	Charlottesville
PCP State	VA

PCP Zip	229011456
PCP County	
Office ID	P9120193
Office Name	PRIVIA MEDICAL GROUP LLC

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

comments His mother always goes over his information with him

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

comments His nursing home is giving him his medications.

6. How confident are you in filling out medical forms by yourself?

- ☐ Not at All Confident ☐ Not Very Confident ☒ Confident
☐ Very Confident

comments His parents are filling in his medical forms form him.

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

comments His parents come and spend time with him and take him out as often as they can. Also, they work with him at his nursing home.

9. Where do you currently live?

- ☐ Home ☐ Apartment ☐ Assisted Living
☒ Nursing Home ☐ Homeless ☐ Other

comments Has been there since August 18, 2018 and is there for long term.

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

comments stopped in 2016

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

comments

stopped in 2016

How many drinks	How Often
9-12	Year

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

☐ Name

Henry & Betty Eppard

☐ Relationship

Parents

17. Do you have a Durable Power of Attorney?

- ☒ **Yes**
☐ No
 ☐ Don't Know

☐ Name

Henry & Betty Eppard

☐ Relationship

Parents

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
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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

Comment:

can feed himself but sometimes he gets a little choked, pockets food and water in his mouth sometimes.

G. Walking	No	Need Some Help	Need Total Help
------------	----	----------------	-----------------

Comment:

Uses a cane - left sided weakness and contraction on his LUE

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

Comment:

Unsure how often he is seen.

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

If one or more, describe

He lives at a nursing home.

E. Had Surgery	None	1	2	3	4	5 or more
----------------	------	---	---	---	---	-----------

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

☒ Yes

☐ No

Describe

strokes (4)

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
Father	arthritis - bilateral knees, hip replacement	still living
Mother	thyroid disease	still living
Sibling1	1 brother & 1 sister	still living

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	No

Breast Exam/Mammography	Not Applicable
Cervical Screening	Not Applicable
Bone Density	Not Applicable
Prostate Exam/PSA	No
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

Educated patient on the importance of getting a colonoscopy. Will send a referral to assist with getting him set up for one.

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

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	
heart health	Aspirin	81mg	PO = By Mouth	QD	Dr. ASAORAGOS TA	Taking	Not Taking
constipation	Colace	100mg	PO = By Mouth	PRN	DR. ASAORAGOS TA	Taking	Not Taking

hyperlipidemia	Crestor	10mg	PO = By Mouth	QD	DR. ASAORAGOS TA	Taking	Not Taking
anxiety and depression	Lexapro	5mg	PO = By Mouth	QD	DR. ASAORAGOS TA	Taking	Not Taking
constipation	Miralax	17g	PO = By Mouth	PRN	DR. ASAORAGOS TA	Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ **Yes** ☐ **No**

Date	Description	Dose/Units	Route	Frequency
07-10-2021	Fish oil	1 tablet	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**

Do you wear glasses or contacts?

☐ Yes ☒ **No**

Do you have problems seeing at night?

☐ Yes ☒ **No**

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

☐ Yes ☒ **No**

Nose Problems (Nose Bleeds, Sinus infections, Other)

☐ Yes ☒ **No**

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

☒ Yes ☐ No

Diagnoses

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

Describe

☒ **Active** ☐ History of ☐ Rule out

comments

sometimes he will choke when he eats.

Have you had a stroke

☒ Yes ☐ No

Do you eat a special diet

☒ Yes ☐ No

comments

He gets his meats cut up small to prevent choking.

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes ☒ No

Respiratory Problems (COPD, Emphysema, Asthma, Chronic Bronchitis Pneumonia, Other)

☐ Yes ☒ No

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

☒ Yes ☐ No

Diagnoses

<input type="checkbox"/> Abnormal Cardiac Rhythm	<input type="checkbox"/> Aneurysm
<input type="checkbox"/> Angina	<input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> Cardio – Respiratory Failure / Shock	<input type="checkbox"/> Cardiomyopathy
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Deep Vein Thrombosis
<input checked="" type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Ischemic Heart Disease (CAD)	<input type="checkbox"/> Myocardial Infarction
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Pulmonary Hypertension
<input type="checkbox"/> Valvular Disease	<input type="checkbox"/> Other

Hyperlipidemia

Describe

☒ **Active** ☐ History of ☐ Rule out

Supported by

☐ Lab results ☒ **Medication** ☐ Other

comments

Taking Crestor

Is patient on Statin

☒ 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

☐ 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

comments

resolved

Supported by

☒ Heartburn /
Dyspepsia

☐ Regurgitation

☐ Medications

☐ Other

Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ History

☒ Medications

☐ Biopsy

☐ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

Other

comments

constipation occasionally - Miralax and Colace when needed
Occasional bowel incontinence not all the time.

History of blood in stool

☐ Yes

☒ No

History of black stools

☐ Yes

☒ No

History of Heartburn / Dyspepsia

☐ Yes

☒ No

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

comments

Nothing currently

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

- ☐ Alcohol Dependence
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Bipolar Disorder
- ☐ Cerebral Hemorrhage

☐ Cerebral Palsy

☐ Dementia

☐ Drug Dependence

☒ Generalized Anxiety Disorder

☒ Hemiparesis

☐ Insomnia

☐ Migraine Headaches

☐ Muscular Dystrophy

☐ Parkinson's disease

☐ Restless leg syndrome

☐ Seizure Disorder

☒ Stroke

☐ TIA

☒ Other

Depression

Describe

☒ Active

Supported by

☐ Symptoms

☐ Other

Major

☒ Yes

Supported by

☐ PHQ 9

☐ History of

☐ PHQ 2 / 9

☐ NO

☐ Hospitalization

☐ Rule out

☒ Use of antidepressant medication

☒ Chronic use of antidepressant medication beyond 6 months

☐ Use of ECT

comments

Taking Lexapro

Generalized Anxiety Disorder

Describe

☒ Active

Supported by

☐ Symptoms

☐ Other

☐ History of

☐ GAD 7

☐ Rule out

☒ Antianxiety medication

comments

Taking Lexapro

Hemiparesis

Describe

☒ Active

Describe

☒ Left sided

Supported by

☐ Physical findings

☐ History Of

☐ Right sided

☒ History

☐ Rule out

☐ Other

Stroke

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Hospitalization

☐ Image study

☐ Physical findings

☐ Sensory findings

☐ Other

comments

has a history of 4 last one was November 2016

Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☐ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Other

comments

short term memory loss

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

↳ If abnormal,

☐ Paranoia

☐ Delusional

☐ Disorganized thought

☒ Flat

☐ Manic

☐ Depressed

☐ Other

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
- ☐ Right
- ☐ Both
- ☒ Left

Heel (Shin) to Toe

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

Thumb to Finger Tips

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

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
- ☐ BPH
- ☐ Chronic Kidney Disease
- ☐ ESRD
- ☐ Erectile Dysfunction
- ☐ Frequent UTI
- ☐ Kidney Stones
- ☐ Nephritis or Nephrosis
- ☒ Urinary Incontinence
- ☐ Other

Urinary Incontinence

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☒ **History**

☐ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Related to stress

☒ **Yes**

☐ No

Related to

☒ **Dribbling**

☐ Urgency

☐ Other

Describe

☒ **Daily**

☐ Few times a week

☐ Less than once a week

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**

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
- ☐ Diabetes
- ☐ Coronary Artery Disease and Diabetes
- ☒ Diabetes
- ☐ Secondary Hyperparathyroidism
- ☐ Hyperthyroidism
- ☐ Kidney Stone
- ☐ Peripheral Vascular Disease secondary to Diabetes
- ☐ Other

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

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

Other

Describe

comments

Diet Controlled

Type

- ☐ Type 1
- ☒ Type 2
- ☐ Gestational

Most recent Hb A1C, value

comments

5.7

And Date

comments

over a year ago

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
- ☐ Exercise
- ☐ Weight loss

comments

Went to meetings at UVA before his last stroke in 2016.

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

Have you lost weight in the past 6 months?

☒ None ☐ 5lbs ☐ 10lbs
☐ 15lbs ☐ More than 15lbs ☐ 10% of your weight
(calculated by assessor)

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

☐ Yes ☒ No

Cancer

Diagnosis of Cancer	Yes	No
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Pain

Does the patient experience pain?

☐ Yes ☒ No

Vital Signs

Vital Signs

comments Unable to obtain a complete set of VS due to virtual visit.

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
(mmHG)	(mmHG)	(bpm)				0

BMI

Patients Height		Patients Weight	Calculate BMI
6 (Feet)	0 (Inch)	170 (lbs)	23.1

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

Exam Review

Constitutional

General appearance:	Normal	Abnormal
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Head and Face

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

Eyes

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

Ears, Nose, Mouth and Throat

External Inspection of ears and nose:	Normal	Abnormal
Otoscopic examination:	Normal	Abnormal
Assessment of hearing:	Normal	Abnormal
Inspection of nasal mucosa, septum and 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

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
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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
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Comment: patient has a walking stick and limps when he ambulates

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

Comment: His LUE has some contraction noted

Assessment of range of motion:	Normal	Abnormal
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Comment: Decreased ROM in LUE due to contraction

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

Asked pt what they smelled, asked pt to read off their medications, blinking of eyes, performed fields of gaze, asked pt to clench teeth, shrug shoulders, swallow, stick out their tongue, smile, and move neck and extremities through ROM, asked patient to stand up, take a couple of steps forwards, backwards, and to sit back down.

Indicate cranial nerve deficits found

Romberg Test	Normal	Abnormal
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
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Orientation of person, place and time:	Normal	Abnormal
Comment: Disoriented to time		
Recent and remote memory:	Normal	Abnormal
Comment: Poor remove memory		
Mood and affect:	Normal	Abnormal
Comment: flat affect		

Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnoses	Comments
DIGITAL_RETINAL_EXAM	Yes	Select			No				Unable to perform due to virtual visit
HBA1C	Yes	Mail Kit Direct to member			No				Unable to perform due to virtual visit.
MICROALBUMIN	Yes	Mail Kit Direct to member			No				Unable to perform due to virtual visit.
FOBT	No	Select			Select				
DEXA	N/A	Select			Select				
PAD	Yes	Mail Kit Direct to member			No				Unable to perform due to virtual visit.
LDL	No	Select			Select				

Mini-Cog

39. Mini- Cog (see attached sheet)

comments Unable to perform due to them not having writing utensils available for use.

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 : --

Person's Answers: --

Word Recall :	-- Points	1 point for each word spontaneously recalled without cueing. Home Safety Yes
Clock Draw :	-- 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 :	-- 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 all sleeping a rooms?	Yes	No
h. Do you have carbon Monoxide detectors on each level of the house?	Yes	No
i. Have used established an escape route in the event of fire?	Yes	No

42. Are there things about yourself you wish you could change or improve?

Would like to go back to the time before he had the 4 strokes.

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

No

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 :

This is a completed audio & video virtual visit. Verbal consent was received by the patient to conduct this virtual visit. Patient identity was verified by address and DOB. Palpation, percussion, and auscultation portions of the assessment were unable to be performed due to this being a virtual visit. Unable to obtain complete set of VS, during HRA visit, due to virtual visit. Patient's mother Betty Eppard was present for the visit and assisted patient with answering assessment questions. Wants to transfer to Albemarle Health and Rehab and needs assistance with scheduling his preventative care visits. Will send referral.

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 :	2021-07-10T15:08
Time exam finished	2021-07-10T15:55
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input checked="" type="checkbox"/>
Provider Signature	<div>   <div> Digitally signed by Candace Hembrick , FNP 2021-07-17, 11:32 </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?