

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	CELIA CARTER
Evaluator Name :	test clinicianFE, FNP
Assessment Type :	Health Risk Assessment
DOB :	1984-03-11
Evaluation Date :	2022-8-10 10:19 AM
Visit Type :	In Person

Demographics

Plan	VPHP
Program	MEDICARE
LOB	DSNP
Name	CELIA CARTER
Gender	Female
Address	800 DAPHIA CIRCLE
City	NEWPORT NEWS
State	VA
Zip	6566809
Date of Birth	1984-03-11
Age(as of date)	38
Marital Status	Separated
Member Identification Number	11000055
HICN	
Phone Number	
Cell Number	
Alternate Contact Number	
Email	abc@gmail.com
Emergency Contact	
Phone Number	
Primary Care Physician	MAJUMDAR, SOHINI
Phone Number	
PCP Address	2148 W Mercury Blvd
PCP City	Hampton
PCP State	VA

PCP Zip	236663111
PCP County	
Office ID	
Office Name	RIVERSIDE MERCURY WEST

1. Race

- | | | |
|---|---|--|
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> African American | <input checked="" 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 | | |

Preferred language

- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> English | <input checked="" type="checkbox"/> Other | |
| ↳ If other, | | |
| <input type="checkbox"/> African languages | <input type="checkbox"/> Arabic | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> French | <input type="checkbox"/> French Creole | <input type="checkbox"/> German |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Gujarati | <input type="checkbox"/> Hebrew |
| <input type="checkbox"/> Hindi | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Italian |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Persian |
| <input type="checkbox"/> Polish | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Scandinavian Languages | <input type="checkbox"/> Serbo-Croatian | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Urdu | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Yiddish | | |

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?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Developed Shortness of breath?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No

Self-Assessment and Social History

How much school have you completed?

- ☐ Completed less than 3rd grade
 ☐ Completed less than 8th grade
 ☐ Completed less than 12th grade
 ☒ **Completed 12th grade, or attended College**

When you get written information at a doctor's office would you say it is

- ☐ Very difficult
 ☐ Somewhat difficult
 ☒ **Easy**
☐ Very easy to understand

When you read the instructions on a prescription bottle would you say that it is

- ☐ Very difficult
 ☒ **Somewhat difficult**
☐ Easy
 ☐ Very easy to understand

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

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

How would you rate your health compared to other persons your age?

- ☐ Excellent
 ☐ Good
 ☐ Fair
 ☐ Poor

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

Where do you currently live?

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

Do you have someone you can rely on to help if you are sick or have problems you need to discuss?

- ☐ Yes
 ☒ **No**

Who do you currently live with?

- ☐ Alone
 ☐ Spouse
 ☒ **Partner**
☐ Relative
 ☐ Family
 ☐ Friend
 ☐ Personal Care Worker

Are you currently a caregiver for someone?

- ☐ Yes
 ☐ No

Are you currently employed?

- ☐ Yes
 ☒ **No**

Are you interested in employment?

☐ Yes

☒ No

Do you volunteer currently?

☐ Yes

☒ No

Tobacco use

☒ Current

☐ Former

☐ Never

Type

☒ Cigarettes

☐ Vaping

☐ Cigars

☐ Other

☐ Chewing Tobacco

How Many

☐ 1 - 3 a day

☐ More than 1 pack

☐ 1/2 a pack

☐ Other

☐ 1 pack

Discussed smoking cessation options, member verbalized understanding

Alcohol Use

☒ Current

☐ Former

☐ Never

How many drinks	How Often
4	Month

Do you or have you used recreational drugs?

☒ Yes

☐ No

Which drugs

Do you have a Healthcare Proxy?

☒ Yes

☐ No

☐ Don't Know

Name

Relationship

Do you have a Durable Power of Attorney?

☐ Yes

☒ No

☐ Don't Know

Do you have an Advance Directive?

☐ Yes

☐ No

☒ Don't Know

☒ Member educated on advance care planning

☐ Declines discussion at this time

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

comments

yyyy

- Recommendations
- ☒ Smoking/Tobacco
- ☐ Substance Abuse
- ☒ Durable Power of attorney
- ☒ Healthcare Proxy
- ☒ Advanced Directive
- ☐ Food Disparity
- ☒ Literacy
- ☐ Social support evaluation

Activities of Daily Living

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

How far can you walk

H. Going up or down stairs	No	Need Some Help	Need Total Help
----------------------------	----	----------------	-----------------

Medical History

Do you use any assistive devices or DME?

☐ None

☐ Cane

☒ Oxygen

☐ Urinal

☐ Other

Describe

☐ PRN

☐ Night

Litres / Min

☐ Walker

☐ Wheel Chair

☐ Bed Pan

☐ Prosthesis

☐ Bedside Commode

☒ CPAP

☐ Continuous

☐ Day

Are you currently seeing any specialists?

☒ Yes ☐ No

Medical Specialty	Specialist	For
Ophthalmologist		

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](#)

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

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

☒ Yes ☐ No

[Describe](#)

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
Adult Day Care	Yes	No

In the past year 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

Family History

☒ Yes
☐ No

Family Member	Medical Condition	Cause of Death
Father		

Preventive Care

In the past three years have you had?

Screen	Answer	Date	Method	Recommendation	Education Completed
Breast Cancer Screening	Yes	4/2022	mammogram	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Colorectal Screening				<input type="checkbox"/>	<input checked="" type="checkbox"/>
Influenza Vaccine			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
COVID-19 Vaccine			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pneumococcal Vaccine			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Herpes Zoster Vaccine			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Diabetes Screening			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Diabetic Foot Exam			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cholesterol Screening			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Glaucoma Screening			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
STIs/HIV Screening			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cervical Cancer Screening			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Osteoporosis Screening				<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prostate Screening			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Fall Risk Screening			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

☐ Yes
☐ No
☐ NA

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

☐ Yes
☐ No
☒ NA

Recommendations

- ☒ Abdominal Aneurysm Screening
☐ Hepatitis C Screening

Allergies / Medications

35. Allergies

☒ Yes
☐ No

Substance	Reaction

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
						Taking	Not Taking
	LEVOTHYROXIN	TAB 112MCG	Select	Select		Taking	Not Taking
	TAMSULOSIN	CAP 0.4MG	Select	Select		Taking	Not Taking
	SMZ/TMP	TAB 800-160	Select	Select		Taking	Not Taking
	EUTHYROX	TAB 100MCG	Select	Select		Taking	Not Taking
	METRONIDAZOL	TAB 500MG	Select	Select		Taking	Not Taking
	TRAMADOL	TAB 50MG	Select	Select		Taking	Not Taking
	SUCRALFATE	TAB 1GM	Select	Select		Taking	Not Taking
	DOXYCYC	CAP 100MG	Select	Select		Taking	Not Taking
	POT CL MICRO	TAB 20MEQ ER	Select	Select		Taking	Not Taking
	PANTOPRAZOLE	TAB 40MG	Select	Select		Taking	Not Taking
	Select		Select	Select		Taking	Not Taking
	Select		Select	Select		Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ Yes
☐ No

Date	Description	Dose/Units	Route	Frequency
09-09-2022				

--	--	--	--	--

Long Term Use of:

- ☐ None
 ☐ ASA
 ☒ **Steroids**
☐ Insulin
- ☐ Anticoagulants
 ☐ Statins
 ☐ Biphosphonate

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

Recommendations

- ☒ Discuss options with your Doctor and/or pharmacist to improve medication adherence
 ☐ Discuss medication side effects with your Doctor
 ☒ Other
- ☒ Educated on importance of medication compliance, member verbalizes understanding

Review of Systems and Diagnoses

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

- ☒ Yes
 ☐ No

Diagnoses

- ☒ **Cataracts**
☐ Glaucoma
 ☐ Hyperopia
 ☐ Legally Blind
 ☐ Macular Degeneration
 ☐ Myopia
 ☐ Retinal Disease
 ☐ Others

Cataracts

Which Eye

- ☒ **Right Eye**
☐ Left Eye
 ☐ Both

Describe

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

Supported by

- ☒ **History**
☒ **Symptoms**
☐ Physical Findings
 ☐ Medications
 ☐ Test results
 ☐ Image studies
 ☐ Biopsy
 ☐ DME
 ☒ **Other**

comments

sees specialist

Symptoms

Type

- ☐ Pain
- ☐ Dry eye
- ☐ Tearing
- ☒ Problem seeing at night
- ☐ Floaters

Secondary to Diabetes

- ☐ Yes
- ☐ No

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

- ☒ Yes
- ☐ No

Diagnoses

- ☒ Difficulty with Hearing
- ☐ Tinnitus
- ☐ Legally Deaf
- ☐ Vertigo

Other

Difficulty with Hearing

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ History
- ☒ Hearing aids
- ☐ Other
- ☐ Symptoms
- ☐ Medication
- ☐ Test results
- ☐ Reading lips

Other

Describe

- ☐ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ History
- ☐ Medications
- ☐ Biopsy
- ☐ Symptoms
- ☐ Test results
- ☐ DME
- ☐ Physical Findings
- ☐ Image studies
- ☐ Other

Other

Nose Problems (Nose Bleeds, Sinus infections, Other)

- ☒ Yes
- ☐ No

Diagnoses

- ☐ Allergic Rhinitis
- ☐ Nose Bleeds
- ☐ Sinus Infections
- ☐ Other
- ☐ Chronic Post Nasal Drip
- ☐ Seasonal Allergies
- ☐ Sinusitis

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

- ☒ Yes
- ☐ No

Diagnoses

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

Neck Problems (parotid Disease, Carotid Stenosis, Other)

- ☒ Yes
- ☐ No

Diagnoses

- | | |
|---|--|
| <input type="checkbox"/> Carotid Stenosis | <input type="checkbox"/> Parotid Disease |
| <input type="checkbox"/> Other | |

Recommendations

- ☒ **Hearing evaluation**
- ☐ Dental exam
- ☒ **Eye exam**
- ☒ **Swallowing evaluation**
- ☐ Take medications as prescribed
- ☒ **Other**

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

- ☒ **Yes** ☐ **No**

Diagnoses

- | | |
|--|--|
| <input type="checkbox"/> Acute Pulmonary Embolism | <input type="checkbox"/> Acute Upper Respiratory Infection |
| <input checked="" type="checkbox"/> Asthma | <input type="checkbox"/> Chronic Pulmonary Embolism |
| <input type="checkbox"/> Chronic Respiratory Failure | <input type="checkbox"/> Chronic Sputum Production |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Hypoventilation secondary to Obesity | <input type="checkbox"/> Hypoxemia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pulmonary Fibrosis |
| <input type="checkbox"/> Respirator Dependence/Tracheostomy Status | <input type="checkbox"/> Respiratory Arrest |
| <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Other | |

Asthma

Describe

- | | | |
|---------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|---------------------------------|-------------------------------------|-----------------------------------|

Supported by

- | | | |
|--|--|--|
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Cyanosis |
| <input checked="" type="checkbox"/> Use of Bronchodilator | <input type="checkbox"/> Use of Inhaled or oral steroids | <input type="checkbox"/> Use of ventilator |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Other | |

Is patient on controller medications

- ☒ **Yes** ☐ **No**

Does patient use rescue medications

- ☐ **Yes** ☐ **No**

Does patient have current exacerbation

- ☐ **Yes** ☐ **No**

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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 checked="" 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

- | | | |
|---------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|---------------------------------|-------------------------------------|-----------------------------------|

↳ Supported by

- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> Lab results | <input type="checkbox"/> Medication | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Light headedness | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Other | |

↳ Is patient on Statin

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

Myocardial Infarction

↳ Describe

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Active (in past 28 days) | <input checked="" type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|---|---|-----------------------------------|

↳ Date

↳ Supported by

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> ECG changes | <input type="checkbox"/> Lab results | <input checked="" type="checkbox"/> History of Hospitalization / Procedure for MI |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Light headedness |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> Other | | |

↳ Is patient taking a Beta Blocker

- | | |
|--|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|--|-----------------------------|

↳ Is patient taking

- | | | |
|----------------------------------|---|----------------------------------|
| <input type="checkbox"/> Aspirin | <input checked="" type="checkbox"/> Plavix | <input type="checkbox"/> Nitrate |
| <input type="checkbox"/> Other | | |

comments

Yes the patient takes Plavix

Recommendations

- ☒ **Blood Pressure checks**
- ☐ Heart Healthy Diet
- ☒ **Exercise 30 min a day**
- ☒ **Take medications as prescribed**
- ☒ **Other**

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

- | | |
|---|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|-----------------------------|

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Bowel Obstruction | <input type="checkbox"/> Cachexia |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Gastroparesis |
| <input type="checkbox"/> GERD | <input type="checkbox"/> GI Bleed |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Inflammatory Bowel Disease |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Ulcer Disease |
| <input type="checkbox"/> Other | |

Recommendations

- ☐ Take medications as prescribed
- ☒ Other

Bowel Movements

- ☐ Normal ☒ Abnormal
- ☐ If abnormal
- ☐ Constipation ☒ Diarrhea ☐ Bowel Incontinence
- ☐ If Diarrhea
- ☐ Acute ☒ Chronic
- ☐ If Diarrhea, history of C Difficile
- ☐ Yes ☒ No

Abdominal Openings

- ☒ Yes ☐ No
- ☐ Describe
- ☐ Ileostomy ☐ Colostomy ☐ Urostomy
- ☐ PEG ☐ Cystostomy

Rectal Problems

- ☒ Yes ☐ No
- ☐ If yes, female
- ☐ Hemorrhoids ☐ Fissure ☐ Mass
- ☐ If yes, male
- ☐ Hemorrhoids ☐ Fissure ☐ Mass
- ☐ BPH ☐ Prostate mass

Last Bowel Movement

- ☐ Today ☐ 1-3 days ago ☐ >3 days ago

Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)

- ☐ Yes ☒ No

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

- ☒ Yes ☐ No

Do you worry too much about different things?

- ☒ Yes ☐ No

comments

Do you worry too much about different things?

Do you feel afraid that something bad might happen?

☒ Yes

☐ No

comments

Do you feel afraid that something bad might happen?

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

DEPRESSION SCREENING PHQ9

Having little interest or pleasure in doing things?

☐ Not at all

☐ Several

☐ More than half the days

☐ Nearly Every Day

Feeling down, depressed or hopeless at times?

☐ Not at all

☐ Several

☐ More than half the days

☐ Nearly Every Day

Do you have trouble falling or staying asleep, sleeping too much?

- ☐ Not at all
- ☐ Several
- ☐ More than half the days
- ☐ Nearly Every Day

Do you feeling tired or having little energy?

- ☐ Not at all
- ☐ Several
- ☐ More than half the days
- ☐ Nearly Every Day

Do you have a poor appetite or overeating?

- ☐ Not at all
- ☐ Several
- ☐ More than half the days
- ☐ Nearly Every Day

Feeling bad about yourself or that you are a failure or have let yourself or your family down?

- ☐ Not at all
- ☐ Several
- ☐ More than half the days
- ☐ Nearly Every Day

Trouble concentrating on things, such as reading the newspaper or watching TV?

- ☐ Not at all
- ☐ Several
- ☐ More than half the days
- ☐ Nearly Every Day

Moving or speaking so slowly that other people have noticed. Or opposite-being fidgety or restless that you have been moving around a lot more than usual?

- ☐ Not at all
- ☐ Several
- ☐ More than half the days
- ☐ Nearly Every Day

Thoughts that you would be better off dead, or hurting yourself?

- ☐ Not at all
- ☐ Several
- ☐ More than half the days
- ☐ Nearly Every Day

PHQ 9 Score

3

If Score is Greater than 15, recommend additional treatment

Score	Depression Severity
1 - 4	Minimal Depression
5 - 9	Mild Depression
10 - 14	Moderate Depression
15 - 19	Moderately Severe Depression
20 - 27	Severe Depression

Speech

- ☐ Normal
- ☐ Slurred
- ☐ Aphasic
- ☐ Apraxia

Finger to Nose

- ☐ Normal
- ☐ Abnormal

Heel (Shin) to Toe

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

Thumb to Finger Tips

- ☐ Normal
- ☐ Abnormal

Sitting to Standing

- ☐ Normal
- ☐ Needs Assistance
- ☐ Unable

Facial / Extremity Movement

- ☐ Motor Tic
- ☐ Vocal Tic
- ☐ Benign (Essential Tremor)
- ☐ Intention Tremor
- ☐ Non-Intention (Pill rolling) Tremor
- ☐ Rigidity
- ☐ Spasticity
- ☐ Chorea Movement
- ☐ Cog wheeling
- ☐ Normal

Gait

- ☐ Normal
- ☐ Limp
- ☐ Wide based
- ☐ Abductor lurch
- ☐ Paretic
- ☐ Shuffling
- ☐ Ataxic
- ☐ Other (Findings may also apply to Musculoskeletal diagnoses)

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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
- ☐ Gynecological
- ☐ Kidney Stones
- ☐ Nephritis or Nephrosis
- ☐ Urinary Incontinence
- ☐ Other

ESRD

Describe

- ☐ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ Lab tests
- ☐ Calculated GFR X 3
- ☐ Symptoms
- ☐ Other

Patient on dialysis

- ☒ **Yes**
- ☐ No

Type

- ☐ Hemodialysis
- ☐ Peritoneal dialysis

- ☒ Location
 - ☐ In Home
 - ☐ Dialysis Center
- ☒ Dialysis schedule
- ☒ Type and location of access device
- ☒ On a special diet
 - ☐ Yes
 - ☐ No

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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

- ☒ Yes
- ☐ No

Diagnoses

- | | |
|---|--|
| <input type="checkbox"/> Collagen (Connective) Tissue Disease | <input type="checkbox"/> Degenerative Disc Disease |
| <input type="checkbox"/> Extremity Fracture | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Hallux Valgus | <input type="checkbox"/> Hammer Toes |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Osteomyelitis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pyogenic Arthritis |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Spinal Stenosis |
| <input type="checkbox"/> Systemic Lupus Erythematosus | <input type="checkbox"/> Other |

Have you had an amputation?

- ☒ Yes
- ☐ No

Describe

Recommendations

- ☐ Discuss PT/OT evaluation with PCP
- ☐ Take medications as prescribed
- ☐ Other

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

- ☒ Yes
- ☐ No

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Dermatitis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Onychomycosis |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Skin ulcer |
| <input type="checkbox"/> Tinea Pedis | <input type="checkbox"/> Urticarial Disease |
| <input type="checkbox"/> Wound | <input type="checkbox"/> Other |

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

Endocrine Problems

- ☒ Yes
- ☐ No

Diagnoses

- ☐ Chronic Kidney Disease secondary
- ☐ Coronary Artery Disease and

<input type="checkbox"/> to Diabetes <input type="checkbox"/> Cushing's Disease <input type="checkbox"/> Diabetic Retinopathy <input type="checkbox"/> Hypertension and Diabetes <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Peripheral Vascular Disease secondary to Diabetes <input type="checkbox"/> Other	Diabetes <input checked="" type="checkbox"/> Diabetes <input type="checkbox"/> Secondary Hyperparathyroidism <input type="checkbox"/> Hyperthyroidism <input checked="" type="checkbox"/> Peripheral Neuropathy secondary to Diabetes <input type="checkbox"/> Hyperparathyroidism
--	---

Diabetes

↳ Describe

<input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
---	-------------------------------------	-----------------------------------

↳ Supported by

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

↳ Type

<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 1.5	<input checked="" type="checkbox"/> Type 2
<input type="checkbox"/> Gestational		

↳ Most recent Hb A1C, value

↳ And Date

↳ Met with a nurse or dietician for diabetic education

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

↳ Met with a diabetic educator

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

↳ Do you test your blood sugar

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

Peripheral Neuropathy secondary to Diabetes

↳ Describe

<input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
---	-------------------------------------	-----------------------------------

↳ Supported by

<input type="checkbox"/> Physical exam	<input checked="" type="checkbox"/> Medication	<input checked="" type="checkbox"/> Symptoms
<input type="checkbox"/> Other		

Symptoms

↳ Describe

<input type="checkbox"/> Numbness	<input type="checkbox"/> Pain	<input type="checkbox"/> Burning
<input checked="" type="checkbox"/> Decreased sensation to legs or feet		

↳ Patient sees Podiatrist

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

Recommendations

- ☐ Take medications as prescribed
- ☐ Check Blood sugar
- ☐ Other

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

- | | |
|--|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|--|-----------------------------|

↳ Diagnoses

- | | |
|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> C. Difficile | <input type="checkbox"/> Community Acquired MRSA Infection |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Herpes Zoster |
| <input type="checkbox"/> Hospital Acquired MRSA Infection | <input type="checkbox"/> Immune Deficiency |
| <input type="checkbox"/> Sepsis | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Sickle Cell Trait | <input type="checkbox"/> Thalassemia |
| <input type="checkbox"/> Thrombocytopenia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Vitamin D Deficiency | <input type="checkbox"/> Other |

Recommendations

- ☐ Take medications as prescribed
- ☐ Report abnormal bruising or bleeding
- ☐ Follow up with doctor for lab work
- ☐ Other

Cancer

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

Describe

- | | | |
|---------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|---------------------------------|-------------------------------------|-----------------------------------|

Supported by

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Physical findings | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Treatments |
| <input type="checkbox"/> Lab tests | <input type="checkbox"/> Imaging studies | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> Other | |

Type

- | | | |
|--------------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Head | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Lung | <input type="checkbox"/> Esophagus |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Liver | <input type="checkbox"/> Pancreas |
| <input type="checkbox"/> Colon | <input type="checkbox"/> Rectum | <input type="checkbox"/> Kidney |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Ovaries | <input type="checkbox"/> Uterus |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Bone | <input type="checkbox"/> Blood |
| <input type="checkbox"/> Lymph Nodes | <input type="checkbox"/> Skin | <input type="checkbox"/> Other |

Specific type/s

Stage or Classification specific to the cancer

Active treatment

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

Is there a current finding of Metastasis?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

Do you see a specialist?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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

↳ Rate your pain on a scale of 1-10, with 1 being very mild and 10 being severe

↳ Frequency of pain

☐ Occasional

☐ One or more times a week

☐ All of the time

Is the Patient Undergoing Pain Management Planning?

☐ Yes ☐ No

Is the member taking a narcotic or Opioid Medication?

☐ Yes ☒ No

Was the patient advised regarding the potential for dependence?

☐ Yes ☐ No

Vital Signs

Vital Signs

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

BMI

Patients Height		Patients Weight	BMI
445 (Feet)	555 (Inch)	66666 (lbs)	1.3

☐ Obesity

☐ Moderate Obesity

☐ Morbid Obesity

☐ Malnutrition

Are you on a special diet?

☐ Heart Healthy Diet

☐ Diabetic Diet

☐ Renal Diet

☐ Vegetarian

☐ Vegan

☐ Gluten Free

☐ Keto

☐ Pescatarian

☐ Other

Have you lost weight in the past 6 months?

☐ None

☐ 5lbs

☐ 10lbs

☐ 15lbs

☐ More than 15lbs

☐ 10% of your weight

(calculated by assessor)

Recommendations

- ☐ Nutrition/ weight management
- ☐ Other

Exam Review

Constitutional

General appearance:	Normal	Abnormal
---------------------	--------	----------

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
Auscultation of lungs:	Normal	Abnormal

Cardiovascular

Auscultation of heart:	Normal	Abnormal
Palpation and auscultation of Carotid Arteries:	Normal	Abnormal
Pedal Pulses:	Normal	Abnormal
Examination of Edema / Varicosities:	Normal	Abnormal

Examination of Radial Pulses:	Normal	Abnormal
-------------------------------	--------	----------

Lymphatic

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

Musculoskeletal

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

Neurologic

Indicate specific cranial nerve tested

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



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

MICROALBUMIN

☐ Yes ☒ No

FOBT

☒ Yes ☐ No

↳ Status options

☐ Member refused ☐ Left kit
☐ Mail Kit direct to member

☐ Collected Sample

↳ FOBT Test Barcode

↳ Exam Date

↳ Screening Result

↳ Diagnosis

↳ Comments

A1C

☒ Yes ☐ No

↳ Status options

☐ Member refused ☐ Left kit
☐ Mail Kit direct to member

☐ Collected Sample

↳ A1C Test Barcode

↳ Exam Date

↳ Screening Result

↳ Diagnosis

↳ Comments

LDL

☒ Yes ☐ No

↳ Status options

☐ Member refused ☐ Left kit
☒ Mail Kit direct to member

☐ Collected Sample

↳ LDL Test Barcode

↳ Exam Date

↳ Screening Result

↳ Diagnosis

↳ Comments

RETINAL EYE EXAM

☒ Yes ☐ No

↳ Status options

☐ Member refused ☐ Exam completed

☒ Environmental issue

↳ Exam Date

↳ Screening Result

↳ Diagnosis

↳ Comments

DEXA

☐ Yes ☒ No

PAD

☐ Yes ☒ No

☐ Member educated on results, verbalized understanding

Mini-Cog

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**

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

Recommendations

☒ Further cognitive evaluation needed
☐ Other

Home Safety & Personal Goals

In the past year how many times have you Fallen?

☐ None ☒ Once ☐ Twice

- ☐ Three times
 ☐ More than three times
- ↳ Do you worry about falling or feeling unsteady when standing or walking
☐ Yes
 ☐ No
- ↳ Worries about falling or feeling unsteady when standing or walking?
☐ Yes
 ☐ No
- ↳ Did you have a fracture in past 6 months?
☐ Yes
 ☐ No

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

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

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

Have you ever physically or felt emotionally abused by someone

- ☐ Yes
 ☐ No

Feeling like harming others or yourself

- ☐ Yes
 ☐ No

Are you afraid of anyone or is anyone hurting you?

- ☐ Yes
 ☐ No



Patient Summary

Assessors Comments :

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 :	
Time exam finished	2022-12-30T00:47
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Provider Signature	  Digitally signed by test clinicianFE, FNP 2022-09-15, 10:43
Addendum	
Addendum Signature	

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?

The information obtained today and any applicable lab results (some of which may become available after subsequent analysis) may be sent to your primary care physician (PCP).