

HRA Form

Health Plan :	Test / Demo Healthcare
Member Name :	TEST MEMBER 44
Evaluator Name :	test clinicianFE, FNP
Assessment Type :	Health Risk Assessment
DOB :	1952-02-05
Evaluation Date :	2022-2-9 05:36 PM
Visit Type :	Virtual: Video & Audio Capability

Demographics

Plan	Demo
Program	TEST
LOB	LOB
Name	TEST MEMBER 44
Gender	Male
Address	123 Main Street
City	unknown
State	un
Zip	00000
Date of Birth	1952-02-05
Age(as of date)	70
Marital Status	Separated
Member Identification Number	400004
HICN	
Phone Number	000-000-0000
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	
Phone Number	000-000-0000
Primary Care Physician	Dr. Red
Phone Number	000-000-0000
PCP Address	123 Central Street
PCP City	unknown
PCP State	un

PCP Zip	00000
PCP County	
Office ID	
Office Name	

### 1. Race

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

### Patient's Ethnicity

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

### Preferred language

- |   |  |                                     |
|---|--|-------------------------------------|
| <input type="checkbox"/> English                | <input checked="" type="checkbox"/> <b>Other</b> |                                     |
| ↳ 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?	Yes	No
Developed Shortness of breath?	Yes	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

comments

home

[Describe](#)

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

- ☒ Yes
 ☐ No

comments

yes

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 ☐ Cigars ☐ Chewing Tobacco  
☐ Vaping ☐ Other

↳ How Many

☐ 1 - 3 a day ☐ 1/2 a pack ☐ 1 pack  
☐ More than 1 pack ☐ Other

↳

☒ Discussed smoking cessation options, member verbalized understanding

Alcohol Use

☒ Current ☐ Former ☐ Never

How many drinks	How Often
2	Week

Do you or have you used recreational drugs?

☒ Yes ☐ No

↳ Which drugs

Do you have a Healthcare Proxy?

☐ Yes ☐ No ☐ Don't Know

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

comments

End of month member struggles with money. He goes to the food bank.

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

### 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
- |  |   |  |
|--|---|--|
| <input checked="" type="checkbox"/> Cane   | <input checked="" type="checkbox"/> Walker      | <input type="checkbox"/> Prosthesis      |
| <input checked="" type="checkbox"/> Oxygen | <input checked="" type="checkbox"/> Wheel Chair | <input type="checkbox"/> Bedside Commode |
| <input type="checkbox"/> Urinal            | <input type="checkbox"/> Bed Pan                | <input checked="" type="checkbox"/> CPAP |
| <input type="checkbox"/> Other             |   |  |
- ↳ Describe
- |                                |                                     |                              |
|--------------------------------|-------------------------------------|------------------------------|
| <input type="checkbox"/> PRN   | <input type="checkbox"/> Continuous | <input type="checkbox"/> Day |
| <input type="checkbox"/> Night |                                     |                              |
- ↳ Litres / Min

### Are you currently seeing any specialists?

☒ Yes

☐ No

Medical Specialty	Specialist	For
Neurologist		

### 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	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Wound Care	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Regular Injections	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Tube Feedings	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Family History

### Family History

☒ Yes
 ☐ No

Family Member	Medical Condition	Cause of Death
Father		

comments

Preventive Care

### In the past three years have you had?

Screen	Answer	Date	Method	Recommendation	Education Completed
Breast Cancer Screening	Not Applicable	4/2022	mammogram	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Colorectal Screening	Yes	11/01	colonoscopy	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Influenza Vaccine	Not Applicable	09/09	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
COVID-19 Vaccine	Don't Know	21/01	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pneumococcal Vaccine	Yes	09/01	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Herpes Zoster Vaccine	No	10/09	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Diabetes Screening	Not Applicable		N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Diabetic Foot Exam	Don't Know	09/10	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Cholesterol Screening	Yes		N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Glaucoma Screening	No	10/02	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
STIs/HIV Screening	Not Applicable		N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Cervical Cancer Screening	Don't Know	03/09	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Osteoporosis Screening	Yes			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prostate Screening	No	10/09	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Fall Risk	Don't Know	10/09	N/A		

Screening				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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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

comments

Recomended

- ☐ Hepatitis C Screening

comments

screening always

Allergies / Medications

35. Allergies

- ☒ Yes
☐ No

Substance	Reaction

comments

HGTFTY

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
HTN	lisinopril		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
05-20-2022				

Long Term Use of:

- ☐ None



- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ASA            | <input checked="" type="checkbox"/> <b>Steroids</b> | <input type="checkbox"/> Insulin       |
| <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Statins                    | <input type="checkbox"/> 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)

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

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

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

#### Nose Problems (Nose Bleeds, Sinus infections, Other)

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

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

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

##### Diagnoses

- |  |   |
|--|---|
| <input type="checkbox"/> Bleeding Gums         | <input type="checkbox"/> Difficulty Chewing |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Other              |

#### Neck Problems (parotid Disease, Carotid Stenosis, Other)

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

##### Diagnoses

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

## Recommendations

☒ **Hearing evaluation**

☐ Dental exam

comments

dental exams

☐ Eye exam

☒ **Swallowing evaluation**

☒ **Take medications as prescribed**

comments

prescribed

☐ Other

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

☐ Yes

☒ **No**

## Recommendations

☒ **Take medications as prescribed**

comments

recommended ssoon

☒ **Other**

comments

OTHERS

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

☐ Yes

☐ No

## Recommendations

☐ Blood Pressure checks

☒ **Heart Healthy Diet**

☒ **Exercise 30 min a day**

☒ **Take medications as prescribed**

comments

Take medicate

☒ **Other**

comments

others

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

☒ **Yes**

☐ No

### Diagnoses

☐ Bowel Obstruction

☐ Celiac Disease

☐ Colon Polyps

☐ Gall Bladder Disease

☐ GERD

☐ Hepatitis

☐ Pancreatitis

☐ Other

☐ Cachexia

☐ Cirrhosis

☐ Diverticulitis

☐ Gastroparesis

☐ GI Bleed

☐ Inflammatory Bowel Disease

☐ Ulcer Disease

## Recommendations

### ☒ Take medications as prescribed

comments

TRAns

### ☐ Other

## Bowel Movements

### ☐ Normal

### ☒ Abnormal

#### ☐ If abnormal

### ☒ Constipation

### ☐ Diarrhea

### ☐ Bowel Incontinence

#### ☐ If Constipation

### ☐ Acute

### ☐ Chronic

## 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

#### ☐ Diagnoses

### ☐ Alcohol Dependence

### ☐ Anxiety

### ☐ Cerebral Hemorrhage

### ☐ Delusional Disease

### ☐ Depression

### ☐ Fibromyalgia

### ☐ Hemiparesis

### ☐ Insomnia

### ☐ Migraine Headaches

### ☐ Muscular Dystrophy

### ☐ Parkinson's disease

### ☐ Restless leg syndrome

### ☐ Seizures

### ☐ Amyotrophic Lateral Sclerosis

### ☐ Bipolar Disorder

### ☐ Cerebral Palsy

### ☐ Dementia

### ☐ Drug Dependence

### ☐ Guillain-Barre Disease

### ☐ Huntington's Chorea

### ☐ Intellectual and or Developmental Disability

### ☐ Multiple Sclerosis

### ☐ Myasthenia Gravis

### ☐ Peripheral Neuropathy

### ☐ Schizophrenia

### ☐ Spinal Cord Injury

- ☐ Stroke
- ☐ TIA
- ☐ Other

- ☐ Subdural Hematoma
- ☐ Traumatic Brain Injury

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 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 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
 ☐ Left
 ☐ Right
 ☐ Both



If abnormal

## Heel (Shin) to Toe

- ☒ Normal
 ☐ Abnormal

## Thumb to Finger Tips

- ☒ Normal
 ☐ Abnormal

## Sitting to Standing

- ☒ Normal
 ☐ Needs Assistance
 ☐ Unable

## Facial / Extremity Movement

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

## Gait

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

## Recommendations

- ☒ Take medications as prescribed
 ☐ Other

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

☒ Yes ☐ No

### Diagnoses

- |   |   |
|---|---|
| <input type="checkbox"/> Acute Renal Failure    | <input type="checkbox"/> BPH                  |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> ESRD                 |
| <input type="checkbox"/> Erectile Dysfunction   | <input type="checkbox"/> Frequent UTI         |
| <input type="checkbox"/> Gynecological          | <input type="checkbox"/> Kidney Stones        |
| <input type="checkbox"/> Nephritis or Nephrosis | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Other                  |   |

## Recommendations

- ☒ Take medications as prescribed  
☒ Other

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

☐ Yes ☒ No

## 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

- |  |  |
|--|--|
| <input type="checkbox"/> Chronic Kidney Disease secondary to Diabetes      | <input type="checkbox"/> Coronary Artery Disease and Diabetes        |
| <input type="checkbox"/> Cushing's Disease                                 | <input type="checkbox"/> Diabetes                                    |
| <input type="checkbox"/> Diabetic Retinopathy                              | <input type="checkbox"/> Secondary Hyperparathyroidism               |
| <input type="checkbox"/> Hypertension and Diabetes                         | <input type="checkbox"/> Hyperthyroidism                             |
| <input type="checkbox"/> Hypothyroidism                                    | <input type="checkbox"/> Peripheral Neuropathy secondary to Diabetes |
| <input type="checkbox"/> Peripheral Vascular Disease secondary to Diabetes | <input type="checkbox"/> Hyperparathyroidism                         |

☐ Other

## Recommendations

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

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

- ☒ Yes ☐ 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

comments

OTHERS

## 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

☒ Yes ☐ No

#### Active treatment

☐ Chemotherapy  
☐ Bone Marrow  
☐ Other

☐ Radiation  
☐ Surgery

☐ Stem Cell  
☐ Immune System

#### Side effects

☐ Nausea  
☐ Anemia  
☐ Weakness

☐ Vomiting  
☐ Neutropenia  
☐ Loss of appetite

☐ Diarrhea  
☐ Thrombocytopenia  
☐ Other

### Is there a current finding of Metastasis?

☐ Yes ☐ No

### Do you see a specialist?

☐ Yes ☐ 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
150 (mmHG)	90 (mmHG)	86 (bpm)	12	99.9	96	6/10

## BMI

Patients Height		Patients Weight	BMI
5 (Feet)	9 (Inch)	240 (lbs)	35.4

- ☐ Obesity
 ☒ **Malnutrition**
- ☐ Moderate Obesity
 ☐ Morbid Obesity
- ☐ Describe
 ☐ Active
 ☐ History of
 ☐ Rule out
- ☐ Malnutrition
 ☐ Yes
 ☐ No
- ☐ Supported by
 ☐ Albumin < 3.5 g/dl
 ☐ Muscle wasting
 ☐ History of severe weight loss

## 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
-------------------------------------	--------	----------

Comment: dry skin

Examination of pupils and irises:	Normal	Abnormal
-----------------------------------	--------	----------

## Ears, Nose, Mouth and Throat

External Inspection of ears and nose:	Normal	Abnormal
---------------------------------------	--------	----------

Comment: dry skin

Otoscopic examination:	Normal	Abnormal
Assessment of hearing:	Normal	Abnormal

Comment: difficult hearing

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

Comment: slight wheezing member notified

## Cardiovascular

Auscultation of heart:	Normal	Abnormal
------------------------	--------	----------

Comment: tachycardia member notified

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

Comment: mass on neck member notified

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

## Musculoskeletal

Examination of gait and station:	Normal	Abnormal
Comment: bilateral knee pain		
Inspection/palpation of digits and nails:	Normal	Abnormal
Comment: fungus on fingernails member notified		
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

1-12

Indicate cranial nerve deficits found

none

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
Orientation of person, place and time:	Normal	Abnormal
Recent and remote memory:	Normal	Abnormal
Mood and affect:	Normal	Abnormal

Comment: depressed

## Screenings Needed

### MICROALBUMIN

☐ Yes ☒ No

## FOBT

☐ Yes ☒ No

## 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

## 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  
Sunrise  
Chair

Leader  
Season  
Table

Village  
Kitchen  
Baby

River  
Nation  
Finger

Captain  
Garden  
Picture

Daughter  
Heaven  
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.

Recommendations

☒ Further cognitive evaluation needed

comments

comments are done

☐ Other

comments

Other values

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 :	2022-02-02T15:37
Time exam finished	2022-02-02T17:37
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input type="checkbox"/>
Preventative Care checklist reviewed and left with member	<input checked="" type="checkbox"/>
Provider Signature	

	<div><div>shwe</div><div></div><div>Digitally signed by test clinicianFE, FNP 2022-02-03, 12:39</div></div>
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).