

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	UNIQUE DAVIS
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1963-09-17
Evaluation Date :	2021-7-20 02:30 PM
Visit Type :	

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICAID
LOB	MLTSS
Name	UNIQUE DAVIS
Gender	Male
Address	3434 DANBURY ROAD
City	RICHMOND
State	VA
Zip	23234-6528
Date of Birth	1963-09-17
Age(as of date)	58
Marital Status	Married
Member Identification Number	10097864
HICN	
Phone Number	8042974723, 8042974723
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	Myglisia Davis
Phone Number	804-297-8985
Primary Care Physician	JOLANTA A HERRERA MD PLLC
Phone Number	8045267990
PCP Address	2552 Aldridge Ave,
PCP City	South Chesterfield
PCP State	VA

PCP Zip	238345306
PCP County	
Office ID	
Office Name	

1. Race

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

Patient's Ethnicity

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

2. Preferred language

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

Previously Documented Conditions

Covid Screening

In the last 14 days, have you:

Traveled internationally?	Yes	No
Had known exposure to anyone diagnosed with Corona virus (COVID-19)	Yes	No
Had close contact with someone who has traveled to a high risk area?	Yes	No
Developed Fever?	Yes	No
Developed Cough?	Yes	No
Developed Flu like symptoms?	Yes	No
Developed Shortness of breath?	Yes	No

Self-Assessment and Social History

3. How much school have you completed?

- | | | |
|---|---|--|
| <input type="checkbox"/> Less than 3rd grade | <input type="checkbox"/> Completed 3rd grade | <input type="checkbox"/> Completed 8th grade |
| <input type="checkbox"/> Completed 12th grade | <input checked="" type="checkbox"/> Attended College | |

comments

2 years of college

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

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

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

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

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

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

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

- ☐ Excellent ☒ **Good** ☐ Fair
☐ Poor

8. During past 3 months, has your physical and or emotional health limited your social activities with family, friends, neighbours or groups?

- ☐ Often ☐ Sometimes ☒ **Almost Never**
☐ Never

9. Where do you currently live?

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

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

- ☒ **Yes** ☐ No

11. Who do you currently live with?

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

12. Are you currently a caregiver for someone?

- ☐ Yes ☒ **No**

13. Tobacco use

- ☐ Current ☐ Former ☒ **Never**

14. Alcohol Use

- ☐ Current ☐ Former ☒ **Never**

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

- ☒ **Yes** ☐ No
↳ Which drugs or medication
oxycodone

16. Do you have a Healthcare Proxy?

☐ Yes
 ☒ No
 ☐ Don't Know

17. Do you have a Durable Power of Attorney?

☐ Yes
 ☒ No
 ☐ Don't Know

18. Do you have an Advance Directive?

☐ Yes
 ☒ No
 ☐ Don't Know

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

☐ Often True
 ☐ Sometimes True
 ☒ Never True

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

☐ Often True
 ☐ Sometimes True
 ☒ Never True

Activities of Daily Living

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

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

Medical History

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

☐ None
 ☒ Cane
 ☐ Walker
 ☐ Prosthesis
 ☐ Wheel Chair
 ☐ Bedside Commode
 ☐ Urinal
 ☐ Bed Pan
 ☐ Other

21. Are you currently seeing any specialists?

☒ Yes
 ☐ No

Medical Specialty	Specialist	For
Other	VCU	achilles tendonitis lt ankle with surgically repaired 4 years ago

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

A. Seen your PCP	None	1	2	3	4	5 or more
------------------	------	---	---	---	---	-----------

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

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

☒ Yes ☐ No

[Describe](#)

covid, pancreatitis, T2DM

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

Physical Therapist	Yes	No
Comment: low back pain; posterior upper neck pain		
Occupational Therapist	Yes	No
Dietician	Yes	No
Comment: diabetes education		
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

comments unknown family history

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	Yes
Breast Exam/Mammography	Not Applicable
Cervical Screening	Not Applicable
Bone Density	Not Applicable
Prostate Exam/PSA	Yes
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

his next colonoscopy is 2023

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

comments

educated on compliance

34. Have you been vaccinated for Herpes Zoster?

- ☐ Yes
 ☒ No

comments

educated on compliance, he did not have chickenpox as a child and therefore does not want the vaccine

Allergies / Medications

35. Allergies

- ☐ Yes
 ☒ No

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
htn	LISINAPRIL	TAB 20MG	PO = By Mouth	QD	herrera	Taking	Not Taking
left ankle pain	DICLOFENAC	GEL 0.01	T = Topical	PRN	herrera	Taking	Not Taking
pancreatitis	CREON	CAP 36000UNT	PO = By Mouth	QD	herrera	Taking	Not Taking
vitamin d deficiency	vitamin d	CAP 50000UNT	PO = By Mouth	QW	herrera	Taking	Not Taking
chronic pain	ACETAMIN	TAB 500MG	PO = By Mouth	PRN	herrera	Taking	Not Taking
chronic pain, pancreatitis	OXYCODONE	TAB 10MG	PO = By Mouth	PRN	herrera	Taking	Not Taking
hyperlipidemia	PRAVASTATIN	TAB 20MG	PO = By Mouth	HS	herrera	Taking	Not Taking
htn	LOSARTAN	TAB 100MG	PO = By Mouth	QD	herrera	Taking	Not Taking
headaches, insomnia	PROPRANOLOL	CAP 60MG ER	PO = By Mouth	HS	herrera	Taking	Not Taking
t2dm	JARDIANCE	TAB 10MG	PO = By Mouth	QD	herrera	Taking	Not Taking
chronic low back pain	LIDOCAINE	PAD 0.05	T = Topical	QOD	herrera	Taking	Not Taking
allergic rhinitis	CLARITIN	TAB 10MG	PO = By Mouth	QD	herrera	Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ Yes

☐ No

Date	Description	Dose/Units	Route	Frequency
07-20-2021	aspirin	81mg	PO = By Mouth	daily

37. Chronic Use of

☐ None

☒ ASA

☐ Anticoagulants

☐ Steroids

☒ Statins

☐ Insulin

☐ 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	Yes	No

you stop taking it?		
6. Do you sometimes forget to refill your prescription on time?	Yes	No

Review of Systems and Diagnoses

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

☒ Yes☐ No

Diagnoses

☐ Cataracts☐ Glaucoma☐ Macular Degeneration☐ Retinal Disease

☒ Difficulty with vision☐ Hyperopia☐ Myopia☐ Others

Describe

☒ Active☐ History of☐ Rule out

Legally Blind

☐ Yes☒ No

Do you wear glasses or contacts?

☒ Yes☐ No

comments

only reading glasses; he last saw ophth about 2 months ago that said he did not have diabetic retinopathy and he can return in 1 year for follow-up

Do you have trouble seeing even with glasses?

☐ Yes☒ No

Do you have problems seeing at night?

☐ Yes☒ No

Do you have eye pain?

☐ Yes☒ No

Do you have problems with tearing?

☐ Yes☒ No

Do you have a problem with dry eye?

☐ Yes☒ No

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

☒ Yes☐ No

Diagnoses

☐ Difficulty with Hearing☐ Tinnitus☒ Other

☐ Legally Deaf☐ Vertigo

Other

Describe

☐ Active☒ History of☐ Rule out

Supported by

☒ History☐ Medications☐ Biopsy

☐ Symptoms☐ Test results☐ DME

☐ Physical Findings☐ Image studies☐ Other

Other

comments

tympanostomy left ear; ruptured eardrum

Do you have trouble hearing when people talk to you?

☒ **Yes**

☐ **No**

comments

issues with left ear

Do you wear a hearing aid?

☐ **Yes**

☒ **No**

Do you read lips?

☐ **Yes**

☒ **No**

Do you have ear pain or drainage?

☐ **Yes**

☒ **No**

Do you ever get dizzy?

☐ **Yes**

☒ **No**

Nose Problems (Nose Bleeds, Sinus infections, Other)

☒ **Yes**

☐ **No**

↳ **Diagnoses**

☐ Chronic Post Nasal Drip

☐ Nose Bleeds

☐ Sinus Infections

☒ **Other**

Other

↳ **Describe**

☒ **Active**

☐ History of

☐ Rule out

↳ **Supported by**

☒ **History**

☐ Symptoms

☐ Physical Findings

☒ **Medications**

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

↳ **Other**

comments

allergic rhinitis

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

☐ **Yes**

☒ **No**

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ **Yes**

☒ **No**

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

☒ **Yes**

☐ **No**

↳ **Diagnoses**

☐ Acute Pulmonary Embolism

☐ Acute Upper Respiratory Infection

☐ Asthma

☐ Chronic Pulmonary Embolism

☐ Chronic Respiratory Failure

☐ Chronic Sputum Production

☐ COPD

☐ Cystic Fibrosis

☐ Hypoventilation secondary to Obesity

☐ Hypoxemia

☐ Pneumonia

☐ Pulmonary Fibrosis

☐ Respirator Dependence/
Tracheostomy Status

☐ Respiratory Arrest

☐ Sarcoidosis

☒ **Sleep Apnea**

☐ Other

Sleep Apnea

↳ Describe

☒ **Active**

☐ History of

☐ Rule out

↳ Supported by

☒ **Use of CPAP**

☐ Positive sleep studies

☐ History of sleepiness during the day

☐ Heavy snoring / restlessness during sleep

☐ Other

Use of Oxygen

☐ Yes

☒ **No**

Shortness of breath

☐ Yes

☒ **No**

Wheezing

☐ Yes

☒ **No**

Chronic Cough

☐ Yes

☒ **No**

Patient requires durable medical equipment

☒ **Yes**

☐ No

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

☒ **Yes**

☐ No

↳ Diagnoses

☐ Abnormal Cardiac Rhythm

☐ Aneurysm

☐ Angina

☐ Atrial Fibrillation

☐ Cardio – Respiratory Failure / Shock

☐ Cardiomyopathy

☐ Congestive Heart Failure

☐ Deep Vein Thrombosis

☒ **Hyperlipidemia**

☒ **Hypertension**

☐ Ischemic Heart Disease (CAD)

☐ Myocardial Infarction

☐ Peripheral Vascular Disease

☐ Pulmonary Hypertension

☐ Valvular Disease

☐ Other

Hyperlipidemia

↳ Describe

☒ **Active**

☐ History of

☐ Rule out

↳ Supported by

☐ Lab results

☒ **Medication**

☐ Other

↳ Is patient on Statin

☒ **Yes**

☐ No

Hypertension

↳ Describe

☒ **Active**

☐ History of

☐ Rule out

↳ Supported by

☐ Physical Exam
☐ Other

☒ Medications

☐ Symptoms

☒ Adequately controlled

☒ Yes

☐ No

☐ UnKnown

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

comments

member tries to eat leaner meats, no salt, no fatty livers, no pork

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

☒ Pancreatitis

☒ Describe

☒ Active

☒ Supported by

☒ Symptoms

☐ Alcoholism

☐ History of

☐ Lab studies

☒ Use of certain medications

☐ Rule out

☐ ERCP

☐ MRI

☐ Cachexia

☐ Cirrhosis

☐ Diverticulitis

☐ Gastroparesis

☐ Hepatitis

☒ Pancreatitis

☐ Other

- ☐ Family history
☒ Recurrent episodes
☒ Yes - Chronic
☐ on a specific diet
☒ Yes
- ☐ Other
☐ No
☐ No

comments

see above

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

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

☐ Bipolar Disorder

☐ 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

☐ History of

☐ Rule out

Supported by

☐ Symptoms

☐ PHQ 2 / 9

☐ Use of antidepressant medication

☒ Other

Other

Describe

comments

former history of amitriptyline for depression; no longer takes the medication; however, sometimes he is down and depressed

- Major

☐ Yes

☒ NO

Insomnia

Describe

☒ Active

☐ History Of

☐ Rule out

Supported by

☒ Medication

☐ Symptoms

☐ History

☐ Other

Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☒ Symptoms

☐ Physical Findings

☒ Medications

☐ Test results

☐ Image studies

☐ Biopsy


☐ DME

☐ Other

Other

comments

migraine

 FOCUSCARE

13

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

↳ Symptoms with headaches of

☐ Visual Changes

☐ Auditory changes

☒ Nausea / vomiting

☐ Sensitivity to light / sound

☐ None

History of auditory hallucinations

☐ Yes

☒ No

History of visual hallucinations

☐ Yes

☒ No

History of psychotic behavior

☐ Yes

☒ No

History of episodes of delirium

☐ Yes

☒ No

Do you follow a special diet?

☒ Yes

☐ No

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

☐ Yes

☒ No

Do you have trouble swallowing your food?

☐ Yes

☒ No

Do you have trouble making people understand you when you speak?

☐ Yes

☒ No

Do you trouble understanding what people say to you?

☐ Yes

☒ No

Do your hands shake?

☐ Yes

☒ No

Do you have convulsions and seizures?

☐ Yes

☒ No

Do you have trouble with your memory?

☐ Yes

☒ No

Do you have trouble finding words?

☐ Yes

☒ No

Do you have trouble sleeping?

☐ Yes

☒ No

Have you lost your appetite

☒ Yes

☐ No

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

☐ Yes

☒ No

Do you have highs and lows

☒ Yes

☐ No

Do you ever feel like someone is out to get you

☐ Yes

☒ No

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

☐ Often

☒ Sometimes

☐ Never

GPCOG Score or MMSE Score

GPCOG Score	or MMSE Score

If GPCOG or MMSE is not done, is

↳ Patient oriented to person

☒ Yes

☐ No

↳ Patient oriented to place

☒ Yes

☐ No

↳ Patient oriented to time

☒ Yes

☐ No

↳ Recall

☒ Good

☐ Poor

↳ Patient describes recent news event

☒ Yes

☐ Partially

☐ No

Affect

☒ Normal

☐ Abnormal

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

Little interest or pleasure in doing things	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

Heel (Shin) to Toe

☒ Normal

☐ Abnormal

Thumb to Finger Tips

☒ Normal

☐ Abnormal

Sitting to Standing

☒ Normal

☐ Needs Assistance

☐ Unable

Facial / Extremity Movement

- ☐ Motor Tic

☐ Intention Tremor

☐ Spasticity

☒ Normal
- ☐ Vocal Tic

☐ Non-Intention (Pill rolling) Tremor

☐ Chorea Movement
- ☐ Benign (Essential Tremor)

☐ Rigidity

☐ Cog wheeling

Gait

- ☒ Normal

☐ Abductor lurch

☐ Ataxic
- ☐ Limp

☐ Paretic

☐ Other (Findings may also apply to Musculoskeletal diagnoses)
- ☐ Wide based

☐ Shuffling

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

☐ Yes

☒ No

comments

member denies history of BPH which is in previously documented conditions

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

☒ Yes

☐ No

Diagnoses

- ☐ Collagen (Connective) Tissue Disease

☐ Extremity Fracture (other than Hip)

☐ Hallux Valgus

☐ Onychomycosis

☐ Osteomyelitis

☐ Pyogenic Arthritis

☐ Spinal Stenosis

☐ Tinea Pedis
- ☐ Degenerative Disc Disease

☐ Gout

☐ Hammer Toes

☐ Osteoarthritis

☐ Osteoporosis

☐ Rheumatoid Arthritis

☐ Systemic Lupus Erythematosus

☒ Other

Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☒ Medications

☐ Biopsy

☒ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

Other

comments

achilles tendinitis; chronic low back pain

History / Finding of non- extremity Fracture

☐ Yes

☒ No

History / Finding of Hip Fracture / Dislocation

☐ Yes

☒ No

History / Finding of Vertebral Fracture

☐ Yes ☒ No

Do you have any swelling of your joints?

☐ Yes ☒ No

Do you experience stiffness in the morning or during the day?

☐ Yes ☒ No

Do you have pain in your joints?

☐ Yes ☒ No

Do you have a problem straightening any joints?

☐ Yes ☒ No

Does pain and or swelling in your joints limit your activities?

☐ Yes ☒ No

Have you broken bones(fractures) in any parts of your body?

☐ Yes ☒ No

Do you have constant pain in your bones?

☐ Yes ☒ No

Have you had an amputation?

☐ Yes ☒ No

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

☐ Yes ☒ No

comments

denies any fungal skin issues (on previous documented conditions)

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 checked="" type="checkbox"/> Diabetes |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Secondary Hyperparathyroidism |
| <input checked="" type="checkbox"/> Hypertension and Diabetes | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Kidney Stone |
| <input type="checkbox"/> Peripheral Neuropathy secondary to Diabetes | <input type="checkbox"/> Peripheral Vascular Disease secondary to Diabetes |
| <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Other |

Diabetes

Describe

☒ **Active** ☐ History of ☐ Rule out

Supported by

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

Type

☐ Type 1 ☒ **Type 2** ☐ Gestational

Most recent Hb A1C, value

comments

5.7% (estimated)

And Date

comments

June 2021

Met with a nurse or dietitian for diabetic education

	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
comments	met with diabetic educator in 2020 during pandemic	
	<input checked="" type="checkbox"/> Met with a diabetic educator	<input type="checkbox"/> No
	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
	<input checked="" type="checkbox"/> Treatment includes	
	<input checked="" type="checkbox"/> Diet	<input type="checkbox"/> Oral hypoglycemic agent
	<input type="checkbox"/> Exercise	<input type="checkbox"/> Insulin agent
		<input type="checkbox"/> Weight loss

comments + oral hypoglycemic agent encouraged member to exercise

Hypertension and Diabetes

Describe

<input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
<input checked="" type="checkbox"/> Supported by		
<input checked="" type="checkbox"/> History	<input type="checkbox"/> Symptoms	<input type="checkbox"/> Physical Findings
<input checked="" type="checkbox"/> Medications	<input type="checkbox"/> Test results	<input type="checkbox"/> Image studies
<input type="checkbox"/> Biopsy	<input type="checkbox"/> DME	<input type="checkbox"/> Other
<input checked="" type="checkbox"/> Is patient on Ace or ARB		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	

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

☐ Yes ☒ **No**

Do you often feel thirsty?

☐ Yes ☒ **No**

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

☐ Yes ☒ **No**

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

☐ Yes ☒ **No**

Do you get ulcers on your legs or feet?

☐ Yes ☒ **No**

Do you feel sluggish?

☐ Yes ☒ **No**

Do you sweat a lot or constantly feel hot?

☐ Yes ☒ **No**

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

☐ Yes ☒ **No**

Have you ever had dialysis?

☐ Yes ☒ **No**

Is your skin itchy?

☐ Yes ☒ **No**

Do you test your blood sugar?

☐ Yes ☒ **No**

Have you lost weight in the past 6 months?

<input checked="" type="checkbox"/> None	<input type="checkbox"/> 5lbs	<input type="checkbox"/> 10lbs
<input type="checkbox"/> 15lbs	<input type="checkbox"/> More than 15lbs	<input type="checkbox"/> 10% of your weight (calculated by assessor)

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

☒ Yes

☐ No

Diagnoses

- ☐ AIDS
- ☐ C. Difficile
- ☐ HIV
- ☐ Hospital Acquired MRSA Infection
- ☐ Leukemia
- ☐ Multiple Myeloma
- ☐ Sickle Cell Disease
- ☐ Thalassemia
- ☐ Tuberculosis
- ☐ Other
- ☐ Anemia
- ☐ Community Acquired MRSA Infection
- ☐ Herpes Zoster
- ☐ Immune Deficiency
- ☐ Lymphoma
- ☐ Sepsis
- ☐ Sickle Cell Trait
- ☐ Thrombocytopenia
- ☒ Vitamin D Deficiency

Vitamin D Deficiency

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Labs

☒ Medications

☐ History

☐ Other

Easy bruising or abnormal bleeding

☐ Yes

☒ No

Long term anticoagulation use

☒ Yes

☐ No

Describe

- ☒ Aspirin
- ☐ Coumadin
- ☐ Thrombin Inhibitors (Pradaxa)
- ☐ Plavix
- ☐ Factor Xa Inhibitors (Xarelto, Eliquis)
- ☐ Other

Cancer

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

Pain

Does the patient experience pain?

☒ Yes

☐ No

Is the Pain Acute?

☐ Yes

☒ No

Is the Pain Chronic?

☒ Yes

☐ No

Describe

☒ Active

☐ History of

☐ Rule out

Where

left ankle, low back, posterior neck pain

Do you take Methadone

☐ Yes ☒ No

What drug/s do you take for it

oxycodone, diclofenac gel, lidocaine patch, tylenol prn

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

8

Is the Patient Undergoing Pain Management Planning?

☒ Yes ☐ No

Is the Patient Responding to the Pain Management Plan?

☒ Yes ☐ No

Was the patient advised regarding the potential for dependence?

☒ Yes ☐ No

Is there any evidence of Maladaptive Behavior?

Tolerance?

☐ Yes ☒ No

Withdrawal?

☐ Yes ☒ No

Increased usage over a longer period that intended?

☐ Yes ☒ No

Desire or unsuccessful effort to cut down on use?

☐ Yes ☒ No

Excess time spent in activities to obtain the substance?

☐ Yes ☒ No

Continued use despite Doctor advice or patient knowledge of habituation?

☐ Yes ☒ No

Physical or Psychological Problem related to the substance use?

☐ Yes ☒ No

Vital Signs

Vital Signs

comments

member in NAD

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
118 (mmHG)	78 (mmHG)	85 (bpm)	18	97.7	97	8

BMI

Patients Height		Patients Weight	Calculate BMI
6 (Feet)	4 (Inch)	295 (lbs)	35.9

- ☐ 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

Comment: deferre

Palpation of chest:	Normal	Abnormal
Auscultation of lungs:	Normal	Abnormal

Cardiovascular

Palpation of heart:	Normal	Abnormal
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Comment: deferred

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

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
Palpation of skin and subcutaneous tissue:	Normal	Abnormal

Neurologic

Indicate specific cranial nerve tested

grossly intact

Indicate cranial nerve deficits found

na

Romberg Test	Normal	Abnormal
Comment:	deferred	

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

Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnosis	Comments
DIGITAL_RETINAL_EXAM	Yes	Completed Kit with Member			Yes	07-20-2021	L: No visually significant pathology, R: No visually significant pathology	Type 2 diabetes mellitus	
HBA1C	Yes	Completed Kit with Member	77000694	77000694	Yes	07-20-2021		Type 2 diabetes mellitus	
MICROALBUMIN	No	Select			Select				
FOBT	Yes	Refused Kit			Select				
DEXA	No	Select			Select				
PAD	No	Select			Select				
LDL	Yes	Select	77000694	77000694	Select				

Mini-Cog

39. Mini- Cog (see attached sheet)

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.1-3 For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test.

Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version : 3

Person's Answers: village, baby, health

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.

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?
member states "my health could be better."

43. Is there anything that you could do to improve your quality of life?
none stated member states "nothing"

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 :

56yo male lives at home with his parents. He uses Rite Aid pharmacy on Weir place in Chester, VA. Member was formely on Lantus Insulin, but brought his A1C down to 5.7% and now only takes oral hypoglycemics. His BG range is 70-110mg/dl. He has issues with his lidocaine patch coverage that was recommended to him inlieu of a lidocaine patch. He needs an alternative that is covered by insurance. Member denies alcohol use or prior abuse; however, previous documented conditions list pancreatitis caused by ETOH abuse. Member denies prior alcohol history.

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 :	2021-07-20T14:33
Time exam finished	2021-07-20T15:08
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Preventative Care checklist reviewed and left with member	<input type="checkbox"/>
Provider Signature	<div><div>Digitally signed by Brittney Walls, FNP 2021-07-25, 23:36</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?