

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	C A WORLEY
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1942-09-19
Evaluation Date :	2021-7-28 09:00 AM
Visit Type :	In Person

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICAID
LOB	MLTSS
Name	C A WORLEY
Gender	Male
Address	970 HILLMAN HIGHWAY
City	ABINGDON
State	VA
Zip	24210-4132
Date of Birth	1942-09-19
Age(as of date)	79
Marital Status	Single
Member Identification Number	10202927
HICN	
Phone Number	276-206-3404, 276-457-9189
Cell Number	276-206-3404
Alternate Contact Number	
Email	
Emergency Contact	Linda Grizzle/ daughter
Phone Number	276-870-8549
Primary Care Physician	JAN RASNAKE, NP (WILL OFFICIALLY ESTABLISH CARE 09/16/21
Phone Number	276-686-3662
PCP Address	7021 W. LEE HWY SUITE C
PCP City	RURAL RETREAT

PCP State	VA
PCP Zip	24368-2933
PCP County	
Office ID	
Office Name	

1. Race

- ☒ **Caucasian**
☐ African American
 ☐ Asian
☐ Latino
 ☐ Native American
 ☐ Native Hawaiian or other Pacific Islander
☐ Alaskan Native
 ☐ Other

Patient's Ethnicity

- ☐ Hispanic
 ☒ **Non-Hispanic**
☐ Other Ethnicity
☐ Prefer not to say

2. Preferred language

- ☒ **English**
☐ Other

Previously Documented Conditions

Covid Screening

In the last 14 days, have you:

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

Self-Assessment and Social History

3. How much school have you completed?

- ☐ Less than 3rd grade
 ☒ **Completed 3rd grade**
☐ Completed 8th grade
☐ Completed 12th grade
 ☐ Attended College

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

☒ Very difficult

☐ Somewhat difficult

☐ Easy

☐ Very easy to understand

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

☒ Very difficult

☐ Somewhat difficult

☐ Easy

☐ Very easy to understand

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

☒ Not at All Confident

☐ Not Very Confident

☐ Confident

☐ Very Confident

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

☐ Excellent

☐ Good

☐ Fair

☒ Poor

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

☐ Often

☐ Sometimes

☒ Almost Never

☐ Never

9. Where do you currently live?

☐ Home

☐ Apartment

☐ Assisted Living

☐ Nursing Home

☐ Homeless

☒ Other

Describe

mobile home

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

☐ Yes

☒ No

comments

patient has neighbors that check on him. his daughter lives another town over but checks on him weekly.

11. Who do you currently live with?

☒ Alone

☐ Spouse

☐ Partner

☐ Relative

☐ Family

☐ Friend

☐ Personal Care Worker

Describe

12. Are you currently a caregiver for someone?

☐ Yes

☒ No

13. Tobacco use

☒ Current

☐ Former

☐ Never

Type

☒ Cigarettes

☐ Cigars

☐ Chewing Tobacco

☐ Vaping


☐ Other

How Many

☐ 1 - 3 a day

☒ 1/2 a pack

☐ 1 pack

 FOCUSCARE

3

☐ More than 1 pack ☐ Other

14. Alcohol Use

☐ Current ☒ **Former** ☐ Never

How many drinks	How Often
5-8	Day

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

☒ **Yes** ☐ No

↳ Which drugs or medication

Patient reports he was seeing another MD for oxycontin due to back pain but has not taken these in about three years.

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

Comment: Patient has had several falls due to Ataxia, weakness, loss of balance. To be safe pt does need assistance with ADLs but as he lives alone he is independent. Pt has a walker but loaned it to his daughter when she broke her foot and has never got it back.

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

How many stairs can you climb

- ☒ None
 ☐ Three to five
 ☐ Six to ten
 ☐ More than ten

Medical History

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

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

21. Are you currently seeing any specialists?

- ☐ Yes
 ☒ No

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

A. Seen your PCP	None	1	2	3	4	5 or more
B. Visited the Emergency Room	None	1	2	3	4	5 or more

If one or more, describe

chest pain/sob

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

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

Physical Therapist	Yes	No
Occupational Therapist	Yes	No
Dietician	Yes	No
Social Worker	Yes	No
Pharmacist	Yes	No
Speech Therapist	Yes	No
Chiropractor	Yes	No
Personal Care Worker (HHA, CNA, PCA)	Yes	No

Meals on Wheels	Yes	No
-----------------	-----	----

25. In the past two years have you received any of the treatments below?

Chemotherapy	Yes	No	Unknown
Catheter Care	Yes	No	Unknown
Oxygen	Yes	No	Unknown

Comment:

2 lpm hs and prn

Wound Care	Yes	No	Unknown
Regular Injections	Yes	No	Unknown
Tube Feedings	Yes	No	Unknown

Family History

26. Family History

☒ Yes

☐ No

Family Member	Medical Condition	Cause of Death
Father		mi
Mother		cancer

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	No
Breast Exam/Mammography	Not Applicable
Cervical Screening	Not Applicable
Bone Density	Not Applicable
Prostate Exam/PSA	Yes
If Diabetic Eye Exam	Yes
If Diabetic Foot Exam	Yes
If Diabetic Hgb A1c screen	Don't Know
Lipid Panel	Don't Know

28. Last colonoscopy if more than 2 years ago

☐ 3 – 5 years ago

☐ 6 – 10 years ago

☐ > 10 years ago

☐ Never

☒ Don't know

29. Screen for abnormal glucose / diabetes - age 40 - 70

☒ Yes

☐ No

☐ NA

30. One time screen for Abdominal Aortic Aneurysm if male with history of smoking, age

65 - 75

☐ Yes

☒ No

☐ NA

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

☐ Yes

☒ No

☐ NA

32. Do you get Flu Vaccine each year?

☐ Yes

☒ No

33. Have you been vaccinated for Pneumonia?

☐ Yes

☒ No

34. Have you been vaccinated for Herpes Zoster?

☐ Yes

☒ No

Allergies / Medications

35. Allergies

☐ Yes

☒ No

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
DM	GLIPIZIDE	TAB 5MG	PO = By Mouth	QD	PCP	Taking	Not Taking
Anemia	FERROUS	TAB 325MG	PO = By Mouth	QD	PCP	Taking	Not Taking
DM	METFORMIN	TAB 1000MG	PO = By Mouth	BID	PCP	Taking	Not Taking
HTN	AMLODIPINE	TAB 5MG	PO = By Mouth	QD	PCP	Taking	Not Taking
COPD	ANORO	AER 62.5-25	Select	QD	PCP	Taking	Not Taking
HTN	LOSARTAN	TAB 100MG	PO = By Mouth	QD	PCP	Taking	Not Taking
BPH	TAMSULOSIN	CAP 0.4MG	PO = By Mouth	HS	PCP	Taking	Not Taking
HTN/EDEMA	FUROSEMIDE	TAB 40MG	PO = By Mouth	QD	PCP	Taking	Not Taking
BPH	FINASTERIDE	TAB 5MG	PO = By Mouth	HS	PCP	Taking	Not Taking
HLD	ATORVASTATIN	TAB 80MG	PO = By Mouth	HS	PCP	Taking	Not Taking
COPD	ALBUTEROL	AER HFA	Select	PRN	PCP	Taking	Not Taking
DM	LANTUS	UNKNOWN	SQ = Subcutaneous	QD	PCP	Taking	Not Taking

36. Over the Counter Medications / Supplements

☐ Yes

☒ No

37. Chronic Use of

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

38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?	Yes	No
2. Do you sometimes not pay enough attention to your medication?	Yes	No
3. Do you know the longterm benefit of taking your medicine as told to you by the doctor or pharmacist?	Yes	No
4. When you feel better do you sometimes stop taking your medicine?	Yes	No
5. Sometimes if you feel worse when you take your medicine do you stop taking it?	Yes	No
6. Do you sometimes forget to refill your prescription on time?	Yes	No

Review of Systems and Diagnoses

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

- ☒ Yes
- ☐ No

Diagnoses

- ☒ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☒ Difficulty with vision
- ☐ Hyperopia
- ☐ Myopia
- ☒ Others

Cataracts

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

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

Secondary to Diabetes

- ☒ Yes
- ☐ No

Difficulty with vision

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

comments

VISION LOSS OF RIGHT EYE

Legally Blind

- ☐ Yes
- ☒ No

Others

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

☐ History
☐ Medications
☐ Biopsy

☒ **Symptoms**
☐ Test results
☐ DME

☐ Physical Findings
☐ Image studies
☐ Other

Other

comments

ARCUS SENILIS OF BOTH EYES

Do you wear glasses or contacts?

☐ 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

Difficulty with Hearing

Describe

☒ **Active**
☐ History of
 ☐ Rule out

Do you have trouble hearing when people talk to you?

☒ Yes
 ☐ No

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

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
- ☐ Asthma
- ☐ Chronic Respiratory Failure
- ☒ COPD
- ☐ Hypoventilation secondary to Obesity
- ☐ Pneumonia
- ☐ Respirator Dependence/ Tracheostomy Status
- ☐ Sarcoidosis
- ☐ Other
- ☐ Acute Upper Respiratory Infection
- ☐ Chronic Pulmonary Embolism
- ☐ Chronic Sputum Production
- ☐ Cystic Fibrosis
- ☐ Hypoxemia
- ☐ Pulmonary Fibrosis
- ☐ Respiratory Arrest
- ☐ Sleep Apnea

COPD

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ Use of accessory muscles
- ☐ Barrel Chest
- ☐ XR results
- ☒ Wheezing
- ☐ Clubbing
- ☒ Decreased or prolonged breath sounds
- ☒ Brinchodilator medication
- ☒ Dyspnea on exertion
- ☒ O2 use

- ☐ Respirator
- ☐ Other

Has patient been told they have Chronic Bronchitis

- ☐ Yes
- ☒ No

Has patient been told they have Emphysema

- ☐ Yes
- ☒ No

Is patient on Bronchodilator

- ☒ Yes
- ☐ No

Route is

- ☒ Inhaled
- ☐ Nebulizer
- ☐ Oral

comments

ALBUTEROL

Is patient on Steroids

- ☒ Yes
- ☐ No

Route is

- ☒ Inhaled
- ☐ Nebulizer
- ☐ Oral

comments

ANORO

Does patient have current exacerbation

- ☐ Yes
- ☒ No

Use of Oxygen

- ☒ Yes
- ☐ No

Describe

- ☒ PRN
- ☐ Continuous
- ☐ Day
- ☐ Night

Litres / Min

2

Shortness of breath

☒ Yes

☐ No

comments

SOB WITH EXERTION

Wheezing

☒ Yes

☐ No

Chronic Cough

☐ Yes

☒ No

Patient requires durable medical equipment

☒ Yes

☐ No

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

☒ Yes

☐ No

Diagnoses

- ☐ Abnormal Cardiac Rhythm
- ☐ Angina
- ☐ Cardio – Respiratory Failure / Shock
- ☒ Congestive Heart Failure
- ☒ Hyperlipidemia
- ☐ Ischemic Heart Disease (CAD)
- ☐ Peripheral Vascular Disease
- ☐ Valvular Disease
- ☐ Aneurysm
- ☐ Atrial Fibrillation
- ☐ Cardiomyopathy
- ☐ Deep Vein Thrombosis
- ☒ Hypertension
- ☐ Myocardial Infarction
- ☐ Pulmonary Hypertension
- ☐ Other

Congestive Heart Failure

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☐ Ejection fraction

☒ DOE

☒ Medications

☐ Cardiomegaly

☐ PND

☐ Peripheral edema

☐ Orthopnea

☐ S3

☐ Other

comments

prescribed Lasix, not taking at this time

Describe

☐ Diastolic

☐ Systolic

☒ Unknown

Secondary to Hypertension

☒ Yes

☐ No

Is patient on an ACE or ARB

☒ Yes

☐ No

comments

prescribed Losartan, not taking at this time

Is patient on a Beta Blocker

☐ Yes

☒ No

Hyperlipidemia

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Lab results

☒ Medication

☐ Other

Is patient on Statin

☒ Yes

☐ No

comments

prescribed Lipitor: not taking at this time

Hypertension

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Physical Exam

☒ Medications

☐ Symptoms

☐ Other

comments

Prescribed Norvasc, Losartan, but not taking at this time

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

comments

prescribed Lasix but not taking at this time

Do you follow a special diet?

☐ Yes

☒ No

Do you have headaches?

☐ Yes

☒ No

Do you feel light headed when you stand up?

☐ Yes

☒ No

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

☒ Yes

☐ No

Diagnoses

☐ Bowel Obstruction

☐ Cachexia

☐ Celiac Disease

☐ Cirrhosis

☐ Colon Polyps

☐ Diverticulitis

☐ Gall Bladder Disease

☐ Gastroparesis

☐ GERD

☐ Hepatitis

☐ Inflammatory Bowel Disease

☐ Pancreatitis

☐ Ulcer Disease

☒ Other

Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ History

☐ Symptoms

☒ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Other

comments

Ventral hernia

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

- | | |
|---|---|
| <input type="checkbox"/> Alcohol Dependence | <input type="checkbox"/> Amyotrophic Lateral Sclerosis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Cerebral Hemorrhage |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Delusional Disease |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Drug Dependence | <input type="checkbox"/> Fibromyalgia |
| <input checked="" type="checkbox"/> Generalized Anxiety Disorder | <input type="checkbox"/> Guillain-Barre Disease |
| <input type="checkbox"/> Hemiparesis | <input type="checkbox"/> Huntington's Chorea |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Intellectual and or Developmental Disability |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Restless leg syndrome | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Subdural Hematoma |
| <input type="checkbox"/> TIA | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Other | |

Generalized Anxiety Disorder

↳ Describe

☐ Active ☒ **History of** ☐ Rule out

↳ Supported by

☒ **Symptoms** ☐ GAD 7 ☐ Antianxiety medication

☐ Other

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

☒ Yes ☐ No

Do you worry too much about different things?

☒ Yes ☐ No

Do you feel afraid that something bad might happen?

☐ Yes ☒ **No**

History of headaches

☐ Yes ☒ **No**

History of auditory hallucinations

☐ Yes ☒ **No**

History of visual hallucinations

☐ Yes ☒ **No**

History of psychotic behavior

☐ Yes ☒ **No**

History of episodes of delirium

☐ Yes ☒ **No**

Do you follow a special diet?

☐ Yes ☒ **No**

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

- ☒ **Yes** ☐ **No**
 Do you have trouble swallowing your food?
- ☐ **Yes** ☒ **No**
 Do you have trouble making people understand you when you speak?
- ☐ **Yes** ☒ **No**
 Do you have 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**

comments

Denies OSA

- ☐ **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

- ☒ **Yes** ☐ **No**
 Patient oriented to person
- ☒ **Yes** ☐ **No**
 Patient oriented to place
- ☒ **Yes** ☐ **No**
 Patient oriented to time
- ☒ **Good** ☐ **Poor**
 Recall
- ☐ **Yes** ☒ **Partially** ☐ **No**
 Patient describes recent news event

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**

comments

due to vision loss and tremors

☐ **If abnormal**

☐ **Left** ☐ **Right** ☒ **Both**

Heel (Shin) to Toe

☒ **Normal** ☐ **Abnormal**

Thumb to Finger Tips

☐ **Normal** ☒ **Abnormal**

comments

due to vision loss and tremors

☐ **If abnormal**

☐ **Left** ☐ **Right** ☒ **Both**

Sitting to Standing

☒ **Normal** ☐ **Needs Assistance** ☐ **Unable**

Facial / Extremity Movement

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

Gait

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

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

☒ **Yes** ☐ **No**

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Acute Renal Failure | <input checked="" 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"/> Kidney Stones | <input type="checkbox"/> Nephritis or Nephrosis |
| <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Other |

BPH

Describe

☒ **Active** ☐ History of ☐ Rule out

Supported by

<input type="checkbox"/> Physical exam	<input checked="" type="checkbox"/> Symptoms	<input type="checkbox"/> Lab test
<input type="checkbox"/> Biopsy	<input checked="" type="checkbox"/> Medication	<input type="checkbox"/> Hospitalization
<input type="checkbox"/> Other		

comments

prescribed Flomax and Finasteride but not taking at this time. Taking OTC Urinozinc for prostate health from wal-mart

History of frequency

☒ **Yes** ☐ **No**



<input type="checkbox"/> 3x / day	<input type="checkbox"/> 4x / day	<input checked="" type="checkbox"/> 5x / day
<input type="checkbox"/> >5x / day		

History of Nocturia

☒ **Yes** ☐ **No**



<input type="checkbox"/> 1x / night	<input type="checkbox"/> 2x / night	<input checked="" type="checkbox"/> 3x / night
<input type="checkbox"/> >=4x / night		

History of Hesitancy

☐ Yes ☒ **No**

Do you have trouble urinating?

☐ Yes ☒ **No**

Do you ever have blood in your urine?

☐ Yes ☒ **No**

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

☒ **Yes** ☐ **No**

Do you have trouble holding your urine?

☐ Yes ☒ **No**

Do you trouble getting to the bathroom on time?

☐ Yes ☒ **No**

Do you ever have pain or burning during urination?

☐ Yes ☒ **No**

Do you ever wear pads or diapers?

☐ Yes ☒ **No**

Do you have a vaginal discharge?

☐ Yes ☒ **No**

Do you have vaginal bleeding?

☐ Yes ☒ No

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

☒ Yes ☐ No

↳ Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Collagen (Connective) Tissue Disease | <input type="checkbox"/> Degenerative Disc Disease |
| <input type="checkbox"/> Extremity Fracture (other than Hip) | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Hallux Valgus | <input type="checkbox"/> Hammer Toes |
| <input type="checkbox"/> Onychomycosis | <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"/> Tinea Pedis | <input checked="" type="checkbox"/> Other |

Other

↳ Describe

☒ Active ☐ History of ☐ Rule out

↳ Supported by

<input type="checkbox"/> History	<input checked="" type="checkbox"/> Symptoms	<input checked="" type="checkbox"/> Physical Findings
<input 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

↳ Other

comments

Dorsalgia and Radiculopathy of lumbar region

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

Endocrine Problems

☒ Yes

☐ No

Diagnoses

- ☐ Chronic Kidney Disease secondary to Diabetes
- ☐ Cushing’s Disease
- ☐ Diabetic Retinopathy
- ☐ Hypertension and Diabetes
- ☐ Hypothyroidism
- ☐ Peripheral Neuropathy secondary to Diabetes
- ☐ Hyperparathyroidism
- ☐ Coronary Artery Disease and Diabetes
- ☒ Diabetes
- ☐ Secondary Hyperparathyroidism
- ☐ Hyperthyroidism
- ☐ Kidney Stone
- ☐ Peripheral Vascular Disease secondary to Diabetes
- ☐ Other

Diabetes

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Symptoms

☐ Physical findings

☒ Lab tests

☒ Medications

☐ Other

comments

prescribed Lantus, Glipizide, and Metformin but is not taking at this time

Type

☐ Type 1

☒ Type 2

☐ Gestational

Most recent Hb A1C, value

comments

unknown

And Date

comments

unknown

Met with a nurse or dietician for diabetic education

☒ Yes

☐ No

Met with a diabetic educator

☐ Yes

☒ No

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

☐ Yes

☒ No

Do you often feel thirsty?

☐ Yes

☒ No

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

☐ Yes

☒ No

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

☒ Yes

☐ No

Do you get ulcers on your legs or feet?

☐ Yes

☒ No

Do you feel sluggish?

☒ Yes

☐ No

Do you sweat a lot or constantly feel hot?

☐ Yes

☒ No

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

- ☐ Yes
- ☒ No

Have you ever had dialysis?

- ☐ Yes
- ☒ No

Is your skin itchy?

- ☐ Yes
- ☒ No

Do you test your blood sugar?

- ☐ Yes
- ☒ No

Have you lost weight in the past 6 months?

- ☒ None
- ☐ 15lbs
- ☐ 5lbs
- ☐ More than 15lbs
- ☐ 10lbs
- ☐ 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

Anemia

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☒ Lab tests
- ☐ Symptoms
- ☐ History of blood transfusion
- ☐ Other

Etiology

- ☒ Iron deficiency
- ☐ Hemolysis
- ☐ Blood loss
- ☐ Other
- ☐ Pernicious
- ☐ Aplastic
- ☐ Chronic Disease
- ☐ Kidney disease
- ☐ Chemotherapy
- ☐ Folate Deficiency

If yes, Patient on

- ☒ Iron
- ☐ B 12
- ☐ Folic Acid
- ☐ Blood Transfusions
- ☐ Other

comments

prescribed Ferrous Sulfate but not taking at this time

Easy bruising or abnormal bleeding

- ☒ Yes
- ☐ No

Long term anticoagulation use

☐ Yes

☒ No

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

Do you take Methadone

☐ Yes

☒ No

What drug/s do you take for it

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

Is the Patient Undergoing Pain Management Planning?

☐ Yes

☒ No

Was the patient advised regarding the potential for dependence?

☐ Yes

☒ No

Is there any evidence of Maladaptive Behavior?

Tolerance?

☐ Yes

☒ No

Withdrawal?

☐ Yes

☒ No

Increased usage over a longer period than intended?

☐ Yes

☒ No

Desire or unsuccessful effort to cut down on use?

☐ Yes

☒ No

Excess time spent in activities to obtain the substance?

☐ Yes

☒ No

Continued use despite Doctor advice or patient knowledge of habituation?

☐ Yes

☒ No

Physical or Psychological Problem related to the substance use?

☐ Yes

☒ No

Vital Signs

Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
164 (mmHG)	80 (mmHG)	76 (bpm)	20	97.7	94	0

BMI

comments

Patient was not able to be weighed as he has difficulty balancing on the scales. Pt stated his weight is approx 250#

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	6 (Inch)	250 (lbs)	40.3

- ☐ 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
---------------------	--------	----------

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

Comment: arcus senilis of both eyes

Ears, Nose, Mouth and Throat

External Inspection of ears and nose:	Normal	Abnormal
Otoscopic examination:	Normal	Abnormal
Assessment of hearing:	Normal	Abnormal

Comment: HOH

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

Comment:

SOB with exertion

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

Comment:

wheezing in all lung fields.

Cardiovascular

Palpation of heart:	Normal	Abnormal
Auscultation of heart:	Normal	Abnormal
Carotid Arteries:	Normal	Abnormal
Abdominal Aorta:	Normal	Abnormal
Pedal Pulses:	Normal	Abnormal
Examination of Arterial Pulses:	Normal	Abnormal
Examination of Edema / Varicosities:	Normal	Abnormal

Comment:

trace edema in BLE's

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

Comment:

slow shuffling gait, impaired balance

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

Comment: loss of balance, frequent falls

Assessment of muscle strength/tone:	Normal	Abnormal
-------------------------------------	--------	----------

Comment: weak hand grip

Skin

Inspection of skin and subcutaneous tissue:	Normal	Abnormal
---	--------	----------

Comment: bruising on both arms

Palpation of skin and subcutaneous tissue:	Normal	Abnormal
--	--------	----------

Neurologic

Indicate specific cranial nerve tested

II-XII

Indicate cranial nerve deficits found

none

Romberg Test	Normal	Abnormal
--------------	--------	----------

Comment: loss of balance

Examination of reflexes:	Normal	Abnormal
Examination of sensation:	Normal	Abnormal
Coordination:	Normal	Abnormal

Comment: loss of balance

Diabetes

Foot Exam:	Normal	Abnormal
------------	--------	----------

Psychiatric

Description of patient's judgement / insight:	Normal	Abnormal
---	--------	----------

Comment: Pt is not taking his medications as prescribed, not checking his BS, not keeping appointments with PCP

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	Diagnoses	Comments
DIGITAL_	Yes	Select			Select				

RETINAL_EXAM									
HBA1C	Yes	Completed Kit with Member	77002361	77002361	Select			DM	
MICROALBUMIN	No	Select			Select				
FOBT	No	Select			Select				
DEXA	No	Select			Select				
PAD	No	Select			Select				
LDL	Yes	Select			Select				

Mini-Cog

39. Mini- Cog (see attached sheet)

comments

Patient was unable to draw a clock due to tremors in hands and difficulty with vision

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: TABLE, BABY, CHAIR

Word Recall :	2 Points	1 point for each word spontaneously recalled without cueing. Home Safety Yes
Clock Draw :	0 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 :	2 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
- ↳ Do you worry about falling or feeling unsteady when standing or walking

☒ Yes

☐ No
- ↳ Worries about falling or feeling unsteady when standing or walking?

☒ Yes

☐ No
- ↳ Did you have a fracture in past 6 months?

☐ Yes

☒ No

41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?	Yes	No
b. Do you have electrical cords running across floors, in doorways or under a rugs?	Yes	No
c. Do you have no slip mats on the shower floor or bath tub?	Yes	No
d. Do have adequate lighting in hallways and on the stairs?	Yes	No
e. Do you have handrails on staircases?	Yes	No
f. Is your hot water heater set for a maximum of 120 degrees?	Yes	No
g. Do you have smoke detectors on each level of the house and in all sleeping a rooms?	Yes	No
h. Do you have carbon Monoxide detectors on each level of the house?	Yes	No
i. Have used established an escape route in the event of fire?	Yes	No

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

NO

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

no

44. Have you ever physically or felt emotionally abused by someone

- ☐ Yes
- ☒ No

45. Feeling like harming others or yourself

- ☐ Yes
- ☒ No

46. Are you afraid of anyone or is anyone hurting you?

- ☐ Yes
- ☒ No

Patient Summary

Assessors Comments :

Pt is a pleasant 78 year old male that lives alone in a mobile home. Pt's neighbor checks on patient and will take him to appointments if needed. Pt was seeing Sarah Johnson, NP at Ballad Health Medical Associates. Provider called their


office and pt has cancelled appointment or no-showed several times over the last year. Pt is scheduled to see Jan Rasnake, NP in Rural Retreat, Virginia Sept. 16th at 3pm. When asked why he was going to transfer from Sarah Johnson, NP who practices in his town and go to a provider over 46 miles away, pt stated his neighbor Eddie goes to Jan Rasnake and he will schedule his appointments on the same day so they can ride together. He is also hopeful the new NP will prescribe pain medication.

Medications reviewed with patient as they come pre-packaged from Northgate Pharmacy. Medications were last filled in both March 2020 and May 2020. Pt has not taken any medications from the package as he states one of them made him sick and he did not know which one and stopped them all. Pt does not give a reply when asked why he cancelled his follow up appointments with his NP.

Provider spent a considerable amount of time instructing pt on importance of taking his medications, checking his BS, using an assistive device with ambulation to prevent falls. Provider educated pt on importance of smoking cessation, compliance with medications regimen, keeping vaccinations, blood work, colonoscopy up to date. Pt verbalized understanding of all instructions. Pt has wheezing in all lung fields. Pt has Anoro and Albuterol inhalers in the home. Provider had pt take his Anoro inhaler during visit and instructed to pt use if every day. Pt instructed if any s/s of respiratory distress, CP, HF to go to the ED for immediate evaluation. Pt verbalized understanding. Referral to be sent to case management to assess for social work or personal care worker evaluation, as well as a Life Alert

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 :	2021-07-28T09:05
Time exam finished	2021-07-28T10:30
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Preventative Care checklist reviewed and left with member	<input type="checkbox"/>
Provider Signature	<div><div>Leslie Berryman, NP-C</div><div>Digitally signed by Leslie Berryman, FNP 2021-07-28, 15:52</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?