

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	BEATRICE M BALBUENA
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1971-03-18
Evaluation Date :	2021-7-28 12:50 PM
Visit Type :	In Person

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICAID
LOB	VPM4
Name	BEATRICE M BALBUENA
Gender	Female
Address	606 WESTOVER HILLS BOULEVARD
City	RICHMOND
State	VA
Zip	23225-4560
Date of Birth	1971-03-18
Age(as of date)	50
Marital Status	Divorced
Member Identification Number	4589316
HICN	
Phone Number	8045908911, 8045908911
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	Angel Rodriguez-son
Phone Number	646-202-3939
Primary Care Physician	Dr. Dipasquale
Phone Number	
PCP Address	9460 Amberdale Dr Ste A,
PCP City	North Chesterfield
PCP State	VA

PCP Zip	232361259
PCP County	
Office ID	
Office Name	

1. Race

- | | | |
|---|---|--|
| <input type="checkbox"/> Caucasian | <input 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 checked="" type="checkbox"/> Other | |
- ☐ Describe
Hispanic

Patient's Ethnicity

- | | | |
|--|---------------------------------------|--|
| <input checked="" type="checkbox"/> Hispanic | <input 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 checked="" type="checkbox"/> Completed 12th grade | <input type="checkbox"/> 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

comments

member states "between fair and 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
 ☒ **Other**
☐ Nursing Home
 ☐ Homeless
- ☒ **Describe**
 Townhome

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
 ☒ **Family**
☐ Relative
 ☐ Friend
 ☐ Personal Care Worker

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**
☐ More than 1 pack
 ☐ Other

comments

quit in 2019

14. Alcohol Use

☐ Current ☐ Former ☒ **Never**

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

☐ Yes ☒ **No**

16. Do you have a Healthcare Proxy?

☐ Yes ☒ **No** ☐ Don't Know

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

comments

rollator walker

21. Are you currently seeing any specialists?

☒ Yes

☐ No

Medical Specialty	Specialist	For
Hematologist	VCU hematology	anemia
Dermatologist	VCU dermatology	hydranitis suppurativa
Other	orthopedist	OA of knees
Other	plastic surgeon	hydranitis suppurativa
Ophthalmologist	VCU optometry and ophth	diabetic retinopathy
Neurologist	VCU neurology	headache, vision loss right eye
Cardiologist	VCU cardiology	tachycardia
Other	bariatric HCA Dr. Schroder	bariatric surgery

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](#)

tachycardia, hydranitis suppurativa, T2DM unhealing wound from surgical excision of abscess, vertigo

C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
-------------------------------------	------	---	---	---	---	-----------

[If one or more, describe](#)

hospitalized over 4 times for wound issues and surgical excision; tachycardia

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

[If one or more, describe](#)

hydranitis suppurativa abscess excision 3-4 times within the last 1 year

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

☒ Yes

☐ No

[Describe](#)

for above reasons and childbirth

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

Physical Therapist	Yes	No
Occupational Therapist	Yes	No
Dietician	Yes	No

Social Worker	Yes	No
Pharmacist	Yes	No
Speech Therapist	Yes	No
Chiropractor	Yes	No
Personal Care Worker (HHA, CNA, PCA)	Yes	No
Meals on Wheels	Yes	No

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

Chemotherapy	Yes	No	Unknown
Catheter Care	Yes	No	Unknown
Oxygen	Yes	No	Unknown
Wound Care	Yes	No	Unknown
Regular Injections	Yes	No	Unknown
Tube Feedings	Yes	No	Unknown

Family History

26. Family History

☒ Yes

☐ No

Family Member	Medical Condition	Cause of Death
Father	cancer (bone, lung, prostate)	father died 2019
Mother	massive MI, CAD, HTN	mom died 2007

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	select
Breast Exam/Mammography	No
Cervical Screening	Yes
Bone Density	No
Prostate Exam/PSA	Not Applicable
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

2019

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

not age eligible, has not been recommended by her PCP yet

34. Have you been vaccinated for Herpes Zoster?

☐ Yes

☒ No

comments

not age eligible, has not been recommended by her PCP yet

Allergies / Medications

35. Allergies

☐ Yes

☒ No

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
headaches	TOPIRAMATE	TAB 100MG	PO = By Mouth	BID	dworetz	Taking	Not Taking
htn	HYDROCHLOROT	TAB 12.5MG	PO = By Mouth	BID	naz	Taking	Not Taking
t2dm	METFORMIN	TAB 500MG	PO = By Mouth	BID	yavuz	Taking	Not Taking
hyperlipidemia	ATORVASTATIN	TAB 40MG	PO = By Mouth	HS	carlton np	Taking	Not Taking
gerd	PANTOPRAZOLE	TAB 40MG	PO = By Mouth	AC	carlton np	Taking	Not Taking
anemia	FEROSUL	TAB 325MG	PO = By Mouth	QD	hull	Taking	Not Taking
vertigo	MECLIZINE	TAB 25MG	PO = By Mouth	TID	naz	Taking	Not Taking
t2dm	victoza	18mg/3ml	SQ = Subcutaneous	QW	dispasquale	Taking	Not Taking
htn	toprol-XL	50mg	PO = By	QD	naz	Taking	Not Taking

			Mouth				
vit d deficiency	vitamin d3	5,000IU	PO = By Mouth	QD	carlton np	Taking	Not Taking
angina	nitroglycerin	0.4mg	S = Sublingual	PRN	naz	Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
07-28-2021	ibuprofen	600mg	PO = By Mouth	TID PRN

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

Others

Describe

☒ Active ☐ History of ☐ Rule out

Supported by

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

Other

comments

blurred vision right eye

- 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

☐ Legally Deaf
- ☐ Tinnitus

☒ Vertigo
- ☐ Other

Vertigo

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☒ History

☒ Symptoms

☐ Physical Findings
- ☒ Medications

☐ Test results

☐ Image studies
- ☐ Biopsy

☐ DME

☐ Other

Do you lose your balance

- ☒ Yes
- ☐ No

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

Does the room spin?

- ☒ Yes
- ☐ No

Do you ever lose your balance?

- ☒ 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

Hypoventilation secondary to Obesity

Describe

☒ Active

☐ History of

☐ Rule Out

Supported by

☒ Morbid Obesity

☐ Use of O2

☐ CO2 Retention

☒ Other

Other

Describe

comments

cpap machine at night

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

comments

she is due for a 2nd sleep study

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

☒ 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

Abnormal Cardiac Rhythm

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ ECG

☐ Electrophysiology procedure / cardioversion

☒ Use of rate controlling drug

☐ Other

☐ Use of anticoagulation

Describe

☐ Bradycardia

☐ Irregularly Irregular

☒ Tachycardia

☐ Premature contractures

☐ Regularly irregular

Angina

Describe

☒ Active

☐ History Of

☐ Rule out

Supported by

☒ Medications

☐ Other

☒ History characterizing chest pain

☒ Stress test

comments

history of stress test 2020

Describe

☒ Stable

☐ Unstable

Hyperlipidemia

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Lab results

☐ Other

☒ Medication

Is patient on Statin

☒ Yes

☐ No

Hypertension

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Physical Exam

☒ Medications

☒ Symptoms

☐ Other

comments

chronic headaches could contribute to hypertension as well.

Adequately controlled

☒ Yes

☐ No

☐ UnKnown

History of Chest Pain

☒ Yes

☐ No

Pain described as

☐ Achy

☐ Sharp

☒ Tight

☐ Crushing

Does pain go into left arm

☐ Yes

☒ No

comments

member states right arm

Is pain reproduced or worsened when touching chest or costochondral junctions

☒ Yes

☐ No

Is pain brought on by

☐ Exertion

☐ Eating

☐ Stress / Anxiety

☒ Other

Other

Describe

member states "it just depends, sometimes comes on just sitting still"

Is pain relieved by oral medication

☒ Yes

☐ No

How long before pain is relieved

☐ 1min

☒ 2min

☐ 5min

☐ >5min

What medication / s

Nitroglycerin

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

comments

6-7 pillows

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

limits meat; eats salads

Do you have headaches?

☒ Yes ☐ No

comments

chronic

Do you feel light headed when you stand up?

☒ Yes ☐ No

comments

at times

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

☒ Yes ☐ No

↳ Diagnoses

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

GERD

↳ Describe

☒ Active ☐ History of ☐ Rule out

↳ Supported by

☒ Heartburn / Dyspepsia ☒ Regurgitation ☒ Medications

☐ Other

History of blood in stool

☐ Yes ☒ No

History of black stools

☐ Yes ☒ No

History of Heartburn / Dyspepsia

☒ Yes ☐ No

↳ Describe

☐ Occasionally ☒ Chronic

History of Vomiting or Regurgitation

☐ Yes ☒ No

History of pain after eating

☒ Yes ☐ No

↳ Describe

☐ Right upper quadrant ☒ Epigastric ☐ Left upper quadrant

☐ Right lower quadrant ☐ Left lower quadrant

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 checked="" 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 checked="" 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 checked="" type="checkbox"/> TIA | <input type="checkbox"/> Traumatic Brain Injury |

- ☐ Other
- Depression
- ☐ Describe
- ☒ Active
- ☐ History of
- ☐ Rule out
- ☐ Supported by
- ☒ Symptoms
- ☐ PHQ 2 / 9
- ☐ Use of antidepressant medication
- ☐ Other

comments

no medications currently

- ☐ Major
- ☐ Yes
- ☒ NO
- Generalized Anxiety Disorder
- ☐ Describe
- ☒ Active
- ☐ History of
- ☐ Rule out
- ☐ Supported by
- ☒ Symptoms
- ☐ GAD 7
- ☐ Antianxiety medication
- ☐ Other

- ☐ Other
- Migraine Headaches
- ☐ Describe
- ☒ Active
- ☐ History of
- ☐ Rule out
- ☐ Supported by
- ☒ History
- ☒ Symptoms
- ☒ Medications
- ☐ Other

- TIA
- ☐ Describe
- ☐ Active
- ☒ History of
- ☐ Rule out
- ☐ Supported by
- ☒ History
- ☐ Physical exam
- ☐ Image studies
- ☐ Other

comments

TIA 2019

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

- ☐ Yes
- ☒ No

Do you worry too much about different things?

- ☒ Yes
- ☐ No

comments

she notices when her BP is high and her heart is beating fast

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

comments

mainly auditory sound - noise needs alleviated and she sits in a quiet room

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
 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 ☐ 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)

comments

assessed during F2F she is stable on her feet without ambulatory aide

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

☐ 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 checked="" 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 type="checkbox"/> Other |

Osteoarthritis

Describe

☒ Active ☐ History of ☐ Rule out

Supported by

☒ Symptoms ☐ Physical Findings ☐ Image studies
☐ Other

Which joints

comments

knees

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

- | | |
|---|--|
| <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 checked="" 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

unknown

↳ And Date

comments

unknown

↳ Met with a nurse or dietician for diabetic education

☒ **Yes** ☐ No

↳ Met with a diabetic educator

☒ **Yes** ☐ No

↳ Treatment includes

☐ Diet ☐ Oral hypoglycemic agent ☒ **Insulin**
☐ Exercise ☐ Weight loss

comments

diet, oral hypoglycemic agent, insulin, scheduled bariatric surgery on 8/3/21

Diabetic Retinopathy

↳ Describe

☒ **Active** ☐ History of ☐ Rule out

↳ Supported by

☐ Funduscopy exam ☐ Vision loss ☒ **Laser Therapy**
☐ Retinal Injections ☐ Surgical procedure ☐ Other

comments

laser procedure and biopsy of right eye on her optic nerve

↳ Patient sees Ophthalmologist

- ☐ Occasionally
 ☐ Once a year
 ☐ Twice a year
 ☒ **>Twice a year**

comments

she sees eye doctor every 3 months

Hypertension and Diabetes

↳ Describe

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

↳ Supported by

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

↳ Is patient on Ace or ARB

- ☒ **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

comments

member checks BG twice daily; range 200-220mg/dl

Have you lost weight in the past 6 months?

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

comments

gained 25 lbs in the last 6 months

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
- ☒ Anemia
- ☐ Community Acquired MRSA Infection
- ☐ Herpes Zoster
- ☐ Immune Deficiency
- ☐ Lymphoma
- ☐ Sepsis
- ☐ Sickle Cell Trait
- ☐ Thrombocytopenia
- ☒ Vitamin D Deficiency

Describe

☒ Active

Supported by

☒ Lab tests

☐ Other

☐ History of

☐ Symptoms

☐ Rule out

☐ History of blood transfusion

comments

Fe 27 on 5/3/21

Etiology

- ☒ Iron deficiency
- ☐ Hemolysis
- ☐ Blood loss
- ☐ Other

- ☐ Pernicious
- ☐ Aplastic
- ☐ Chronic Disease

- ☐ Kidney disease
- ☐ Chemotherapy
- ☐ Folate Deficiency

If yes, Patient on

☒ Iron

☐ Blood Transfusions

☐ B 12

☐ Other

☐ Folic Acid

comments

doctor wants to start iron transfusions after bariatric surgery

Vitamin D Deficiency

Describe

☒ Active

Supported by

☒ Labs

☐ Other

☐ History of

☒ Medications

☐ Rule out

☐ History

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

headaches, knee pain, back pain herniated disc

Do you take Methadone

☐ Yes ☒ No

What drug/s do you take for it

ibuprofen

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

10

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 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

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
128 (mmHG)	78 (mmHG)	88 (bpm)	20	98.1	97	10

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	7 (Inch)	301 (lbs)	47.1

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

Exam Review

Constitutional

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

Comment: obese female

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: deferred

Palpation of chest:	Normal	Abnormal
---------------------	--------	----------

Auscultation of lungs:	Normal	Abnormal
------------------------	--------	----------

Cardiovascular

Palpation of heart:	Normal	Abnormal
---------------------	--------	----------

Comment: deferred

Auscultation of heart:	Normal	Abnormal
Carotid Arteries:	Normal	Abnormal
Abdominal Aorta:	Normal	Abnormal

Comment: obese; abd soft, nondistended, nontender

Pedal Pulses:	Normal	Abnormal
Examination of Arterial Pulses:	Normal	Abnormal
Examination of Edema / Varicosities:	Normal	Abnormal

Comment: +1 b/l ankle edema, non-pitting

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: steady when walking to her refrigerator to get her insulin; no ambulatory aide used during F2F visit

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

Comment: decreased extension right knee

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
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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	Diagnoses	Comments
DIGITAL_RETINAL_EXAM	Yes	Completed Kit with Member			Yes	07-28-2021	images sent	diabetic retinopathy vs. retinopathy caused by chronic steroid use (formerly) Type 2 diabetes mellitus	
HBA1C	Yes	Mail Kit Direct to member			No				discussed with member that company would mail kit since provider is out of kits
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)

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, kitchen, baby

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.

Home Safety & Personal Goals

40. In the past year how many times have you Fallen?

☐ None

☒ Three times

☐ Once

☐ More than three times

☐ Twice

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

Comment: needs to get mats

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?

"my health"

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

"if I was more active I think I would feel better"

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 :


50yo female lives in townhome-setting which she walks up 12 steps to enter her home. She uses a rollator walker to ambulate. She is trying to get a shower chair and raised toilet seat. She says that VAP will call every 2 months and speaks to her rep about it; states her ortho doctor and PCP both want these specialty MDE items to help member with her pain and around the house. She has been "dealing with this" since 2019 when discharged from the hospital for hydrenitis suppurativa.

Member has gastric bypass surgery scheduled on 8/3/2021 at HCA Henrico. Member has chronic comorbidities and would like information on HHA services to help with housework, cleaning, etc. Member has a history of breast reduction and her last mammography was 2-3 years ago and member states "it was cloudy." She

is talking with her PCP about getting her rescheduled for another mammogram after her bariatric surgery next week.
CM referral completed.
NP did not have A1C kits in-home today and member would like one sent to her.

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 :	2021-07-28T12:01
Time exam finished	2021-07-28T13:01
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 2021-07-28, 13:01</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?