

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	ALAN A KING
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1983-05-21
Evaluation Date :	2021-7-26 02:30 PM
Visit Type :	In Person

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICAID
LOB	VPM4
Name	ALAN A KING
Gender	Male
Address	2325 Carmine St
City	RICHMOND
State	VA
Zip	23223-5922
Date of Birth	1983-05-21
Age(as of date)	38
Marital Status	Single
Member Identification Number	6763115
HICN	
Phone Number	8043145403, 8045975407
Cell Number	8043145403
Alternate Contact Number	
Email	
Emergency Contact	Denise King
Phone Number	804-803-6755
Primary Care Physician	No PCP
Phone Number	
PCP Address	
PCP City	
PCP State	

PCP Zip	
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 type="checkbox"/> Attended College | |

comments

GED

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

Type

☒ Cigarettes

☐ Vaping

☐ Cigars

☐ Other

☐ Chewing Tobacco

How Many

☐ 1 - 3 a day

☐ 1/2 a pack

☐ 1 pack

☒ More than 1 pack

☐ Other

comments

smoking cessation discussed with member

14. Alcohol Use

☐ Current
 ☒ Former
 ☐ Never

comments

quit in 2017

How many drinks	How Often
9-12	Day

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

☒ Yes
 ☐ No

Which drugs or medication

oxycodone -stopped 2 months ago

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

comments no specialists - formerly had a wound doctor and rehab

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](#)

cellulitis left leg March 2021

C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
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[If one or more, describe](#)

cellulitis

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](#)

drug, alcohol use

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
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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	No
Breast Exam/Mammography	Not Applicable
Cervical Screening	Not Applicable
Bone Density	Not Applicable
Prostate Exam/PSA	No
If Diabetic Eye Exam	No
If Diabetic Foot Exam	No
If Diabetic Hgb A1c screen	No
Lipid Panel	No

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

comments

discussed preventative care with member

33. Have you been vaccinated for Pneumonia?

☐ Yes ☒ No

comments not recommended at member's age

34. Have you been vaccinated for Herpes Zoster?

☐ Yes ☒ No

comments not recommended at member's age

Allergies / Medications

35. Allergies

☐ Yes ☒ No

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
leg infection	CEFDINIR	CAP 300MG	PO = By Mouth	BID	simons	Taking	Not Taking
nicotine dependence	NICOTINE	DIS 21MG/24H	T = Topical	PRN	soguflu	Taking	Not Taking
opioid abuse	NARCAN	SPR	M = Intramuscular	QD	simons	Taking	Not Taking
chronic pain	IBUPROFEN	TAB 800MG	PO = By Mouth	BID	otc	Taking	Not Taking
pain	GABAPENTIN	TAB 600MG	PO = By Mouth	TID	soguflu	Taking	Not Taking
arthritis	DICLOFENAC	GEL 0.01	PO = By Mouth	QD	simons	Taking	Not Taking
chronic pain	ACETAMINOPHE	TAB 325MG	PO = By Mouth	TID	simons	Taking	Not Taking
PTSD	QUETIAPINE	TAB 100MG	PO = By Mouth	HS	simons	Taking	Not Taking
htn	CLONIDINE	TAB 0.1MG	PO = By Mouth	BID	simons	Taking	Not Taking
anxiety	HYDROXYZ	CAP 50MG	PO = By Mouth	QID	soguflu	Taking	Not Taking
opioid abuse	methadone	100mg	PO = By Mouth	QD	4926 W Broad St	Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
07-26-2021	zinc	500mg	PO = By Mouth	TID - zinc for wound healing

37. Chronic Use of

☒ None

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

Comment: needs a doctor

Review of Systems and Diagnoses

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

☐ Yes ☒ No

Do you wear glasses or contacts?

☐ Yes ☒ No

Do you have problems seeing at night?

☐ Yes ☒ No

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

☐ Yes ☒ No

Nose Problems (Nose Bleeds, Sinus infections, Other)

☐ Yes ☒ No

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

☒ Yes ☐ No

Diagnoses

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

Other

Describe

☒ Active ☐ History of ☐ Rule out

Supported by

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

Other

comments dental caries

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes

☒ No

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

☐ 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

Hypertension

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Physical Exam

☒ Medications

☐ Other

☐ 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

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

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

Alcohol Dependence

↳ Describe

☐ Active ☒ History of ☐ Rule out

↳ Supported by

☒ Drinking history ☐ Hospitalizations ☐ Physical findings
☐ Lab results ☐ Other

↳ History of Delirium Tremens

☒ Yes

☐ No

History of Psychosis

☒ Yes

☐ No

Depression

☐ Describe

☒ Active

☐ History of

☐ Rule out

☐ Supported by

☒ Symptoms

☐ PHQ 2 / 9

☐ Use of antidepressant medication

☐ Other

☐ Major

☒ Yes

☐ NO

☐ Supported by

☒ PHQ 9

☐ Hospitalization

☐ Chronic use of antidepressant medication beyond 6 months

☐ Use of ECT

☐ Drug Dependence

☐ Describe

☒ Active

☐ History of

☐ Rule out

☐ Supported by

☐ Use of recreational drugs

☐ History outpatient treatment

☐ Other

☒ Chronic use of pain medication

☐ Withdrawal symptoms

☒ History of hospitalization

☐ Abnormal affect

☐ History of Psychosis

☐ Yes

☒ No

☐ What drug/s

comments

methadone currently; prior on oxycodone

Generalized Anxiety Disorder

☐ Describe

☒ Active

☐ History of

☐ Rule out

☐ Supported by

☒ Symptoms

☐ GAD 7

☐ Antianxiety medication

☐ Other

Insomnia

☐ Describe

☒ Active

☐ History Of

☐ Rule out

☐ Supported by

☐ Medication


☐ Other

☒ Symptoms

☐ History

Peripheral Neuropathy

☐ Describe



FOCUSCARE

11

☒ Active

☐ History Of

☐ Rule out

↳ Supported by

☒ Physical findings

☐ EMG / Nerve Conduction studies

☐ Biopsy

☒ Other

Other

↳ Describe

comments

caused by leg cellulitis

↳ Secondary to Diabetes

☒ Yes

☐ No

comments

non-healing left leg

Other

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☒ History

☐ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

↳ Other

comments

PTSD

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 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

↳ If abnormal,

☐ Paranoia

☐ Delusional

☒ Disorganized thought

☐ Flat

☐ Manic

☐ Depressed

☐ Other

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

--	--	--	--

Little interest or pleasure in doing things	Not at all	Several Days	More than half the days	Nearly every day
Feeling down, depressed or hopeless	Not at all	Several Days	More than half the days	Nearly every day

PHQ 2 Score

☐ < 3 ☒ 3 or more

DEPRESSION SCREENING PHQ9

Having little interest or pleasure in doing things?

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

Feeling down, depressed or hopeless at times?

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

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

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

Do you feeling tired or having little energy?

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

Do you have a poor appetite or overeating?

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

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

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

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

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

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

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

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

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

PHQ 9 Score

23

If Score is Greater than 15, recommend additional treatment

Speech

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

Finger to Nose

- ☒ Normal
- ☐ Abnormal

Heel (Shin) to Toe

- ☐ Normal
- ☒ Abnormal
- ☐ Right
- ☐ Both
- ☒ Left

comments

left leg wound

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)

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

- ☐ Collagen (Connective) Tissue Disease
- ☐ Degenerative Disc Disease
- ☐ Extremity Fracture (other than Hip)
- ☐ Gout
- ☐ Hallux Valgus
- ☐ Hammer Toes
- ☐ Onychomycosis
- ☐ Osteoarthritis
- ☐ Osteomyelitis
- ☐ Osteoporosis
- ☐ Pyogenic Arthritis
- ☐ Rheumatoid Arthritis

- ☐ Spinal Stenosis

☐ Tinea Pedis

☒ Other

☐ Describe

☒ Active

☐ History

☐ Medications

☐ Biopsy

☐ Other

☐ History of

☒ Symptoms

☐ Test results

☐ DME

☐ Rule out

☐ Physical Findings

☐ Image studies

☐ Other

comments

chronic pain syndrome

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

Diagnoses

- ☐ Basil Cell Carcinoma

☐ Eczema

☐ Skin ulcer

☒ Wound
- ☐ Dermatitis

☐ Psoriasis

☐ Urticarial Disease

☒ Other

Wound

Describe

- ☒ Active

☐ History of

☐ Rule out

Supported by

- ☒ History

☒ Medications

☒ Symptoms

☐ Test results

☒ Physical Findings

☐ Image studies

- ☐ Biopsy

☒ Etiology

☐ Surgical

Other

☒ Describe

☒ Supported by

☒ History

☐ Medications

☐ Biopsy

☒ Other

☐ DME

☒ Traumatic

☐ History of

☒ Symptoms

☐ Test results

☐ DME

☐ Other

☐ Burn

☐ Rule out

☐ Physical Findings

☐ Image studies

☐ Other

comments

cellulitis

Do you have ulcers or wounds that require dressings?

- ☒ Yes
- ☐ No

Do you have a chronic skin condition?

- ☒ Yes
- ☐ No

Does your skin problem require the use of chronic medication, cream or ointment?

- ☒ Yes
- ☐ No

Do you get pains in your legs when you walk that make you stop to get relief?

- ☐ Yes
- ☒ No

Do you have skin breakdown or ulcers around your ankles?

- ☐ Yes
- ☒ No

Endocrine Problems

- ☐ Yes
- ☒ No

Have you lost weight in the past 6 months?

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

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

- ☐ Yes
- ☒ No

Cancer

Diagnosis of Cancer	Yes	No
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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 leg

Do you take Methadone

☒ Yes

☐ No

Where do you get it

Richmond Treatment Center

What drug/s do you take for it

tylenol, 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

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

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
125 (mmHG)	73 (mmHG)	69 (bpm)	18	97.8	94	10

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	9 (Inch)	200 (lbs)	29.5

- ☐ 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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Comment: disheveled appearance

Head and Face

Examination of head and face:	Normal	Abnormal
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Comment: tattoos and multiple healing spots to face

Palpation of the face and sinuses:	Normal	Abnormal
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Comment: refused

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

Comment: refused

Assessment of hearing:	Normal	Abnormal
Inspection of nasal mucosa, septum and turbinates:	Normal	Abnormal
Inspection of lips, teeth and gums:	Normal	Abnormal

Comment: dental caries

Examination of oropharynx:	Normal	Abnormal
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Neck

Examination of neck:	Normal	Abnormal
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Comment: tattoos

Examination of thyroid:	Normal	Abnormal
Comment: deferred		

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
Percussion of chest:	Normal	Abnormal
Comment: deferred		

Palpation of chest:	Normal	Abnormal
Comment: deferred		

Auscultation of lungs:	Normal	Abnormal
Comment: refused		

Cardiovascular

Palpation of heart:	Normal	Abnormal
Comment: deferred		

Auscultation of heart:	Normal	Abnormal
Comment: refused		

Carotid Arteries:	Normal	Abnormal
Comment: refused		

Abdominal Aorta:	Normal	Abnormal
Comment: refused		

Pedal Pulses:	Normal	Abnormal
Comment: refused		

Examination of Arterial Pulses:	Normal	Abnormal
Comment: refused		

Examination of Edema / Varicosities:	Normal	Abnormal
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Lymphatic

Palpation of cervical nodes (neck)	Normal	Abnormal
Comment: deferred		

Palpation of preauricular nodes (in front of the ears)	Normal	Abnormal
Comment: deferred		

Palpation of Submandibular nodes (under jaw line/chin)	Normal	Abnormal
Comment: deferred		

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
Comment: ambulates with steady gait		
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
Comment: tattoos on entire body that's exposed; facial; legs; arms, neck		
Palpation of skin and subcutaneous tissue:	Normal	Abnormal
Comment: deferred		

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
Comment: refused		
Examination of sensation:	Normal	Abnormal
Coordination:	Normal	Abnormal

Diabetes

Foot Exam:	Normal	Abnormal
Comment: refused		

Psychiatric

Description of patient's judgement / insight:	Normal	Abnormal
Orientation of person, place and time:	Normal	Abnormal
Recent and remote memory:	Normal	Abnormal

Mood and affect:	Normal	Abnormal
Comment: flat affect; guarded; disorganized thought process; withdrawn		

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	07-26-2021	L: No diabetic Retinopathy R: No diabetic Retinopathy		
HBA1C	Yes	Refused Kit			Member Refused				
MICROALBUMIN	Yes	Completed Kit with Member	37280086	37280086	Yes	07-26-2021			
FOBT	No	Select			Select				
DEXA	No	Select			Select				
PAD	No	Select			Select				
LDL	Yes	Select			No				no kit available

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, banana

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

↳ 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?

member states "no"

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

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 :

38yo male lives in apartment-setting with significant other and children. He has a long-standing history of alcohol and drug abuse from his previous documented conditions requiring narcan, hospitalization and he was homeless at one point. He did not offer a lot of information or forthcoming. Scattered thoughts, high PHQ-9 score, currently goes to methadone clinic daily. He played play station majority of his F2F exam and did not make eye contact but maybe 30 seconds his entire exam. His PHQ-9 score is 23. Member had flat affect; guarded; disorganized thought process; withdrawn during exam. He would not make eye contact or provide much information. Discussed mental health services with member for which he agrees and would like help with his health. He denies suicide or homicide ideation. Member requested opioid pain medication over and over; history of drug abuse. He has no PCP - needs one for continued care. He goes to Methadone clinic daily.

CM referral completed for mental health services, needs PCP, and social work referral.

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 :	2021-07-26T14:00
Time exam finished	2021-07-26T14:58
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Preventative Care checklist reviewed and left with member	<input type="checkbox"/>
Provider Signature	 <div> Digitally signed by Brittney Walls, FNP 2021-07-28, 22:52 </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?