

HRA Form

Health Plan :	Optima Health
Member Name :	BONNIE L BARTLETT
Evaluator Name :	Jennifer E Edwards, AGNP
Assessment Type :	Health Risk Assessment
DOB :	1955-03-07
Evaluation Date :	2021-4-26 09:00 AM
Visit Type :	In Person

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	BONNIE L BARTLETT
Gender	Female
Address	1201 LONG MEADOWS DR APT G18
City	LYNCHBURG
State	VA
Zip	24502
Date of Birth	1955-03-07
Age(as of date)	66
Marital Status	Single
Member Identification Number	900035672*01
HICN	
Phone Number	434/237-6654
Cell Number	434/237-6654
Alternate Contact Number	
Email	
Emergency Contact	Brian McHenry
Phone Number	856-723-7542
Primary Care Physician	Helen Parke
Phone Number	
PCP Address	
PCP City	LYNCHBURG
PCP State	VA

PCP Zip	
PCP County	LYNCHBURG CITY
Office ID	
Office Name	Community access network

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

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
[🔗](#) Describe

12. Are you currently a caregiver for someone?

- ☐ Yes ☒ **No**

13. Tobacco use

- ☐ Current ☐ Former ☒ **Never**

14. Alcohol Use

- ☐ Current ☐ Former ☒ **Never**

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

- ☐ Yes ☒ **No**

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

↳ How far can you walk

☐ Household only
 ☐ Less than one block
 ☐ One block
 ☒ Two or more blocks
 ☐ Non-ambulatory

Comments: feels that she can probably walk two blocks if she walks slowly, pain in knees prevents her from walking further.

H. Going up or down stairs	No	Need Some Help	Need Total Help
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↳ How many stairs can you climb

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

Comments: currently has to climb 10 stairs to get to her apartment but this is very difficult for her due to pain.

Medical History

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

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

21. Are you currently seeing any specialists?

☒ Yes

☐ No

Medical Specialty	Specialist	For
Psychiatrist	Dr. Wilson	anxiety and depression
Other	Ortho VA, Dr. Collins, Dr. Cox	knee pain, right foot
Oncologist	Dr. Cirenza	breast cancer

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

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

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

☒ Yes

☐ No

[Describe](#)

Depression

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
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Family History

26. Family History

☒ Yes ☐ No

Family Member	Medical Condition	Cause of Death
Father	HTN	unknown
Mother	breast CA	unknown

Preventive Care

27. In the past three years have you had?

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

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

Substance	Reaction
ibuprofen	sores on tongue
penicillian	allergy as child

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
	SERTRALINE TAB	150MG	PO = By Mouth	QD		Taking	Not Taking
	RISPERIDON E TAB	4MG	PO = By Mouth	QPM		Taking	Not Taking
	LETROZOLE TAB	2.5MG	PO = By Mouth	QD		Taking	Not Taking
	TRAZODONE TAB	50MG	PO = By Mouth	PRN		Taking	Not Taking
	SPIRONOLAC T TAB	50MG	PO = By Mouth	QD		Taking	Not Taking
	ATORVASTAT IN TAB	40MG	PO = By Mouth	QPM		Taking	Not Taking
	NIFEDIPINE TAB	30MG ER	PO = By Mouth	QD		Taking	Not Taking
	BUSPIRONE TAB	15MG	PO = By Mouth	BID		Taking	Not Taking
	LISINOPRIL TAB	40MG	PO = By Mouth	QD		Taking	Not Taking
	aspirin	81 mg	PO = By Mouth	QD		Taking	Not Taking
	SERTRALINE	TAB 100MG	Select	Select		Taking	Not Taking
	LETROZOLE	TAB 2.5MG	Select	Select		Taking	Not Taking
	BUSPIRONE	TAB 15MG	Select	Select		Taking	Not Taking
	NIFEDIPINE	TAB 30MG ER	Select	Select		Taking	Not Taking
	SPIRONOLA CT	TAB 50MG	Select	Select		Taking	Not Taking
	TRAZODONE	TAB 50MG	Select	Select		Taking	Not Taking
	LISINOPRIL	TAB 40MG	Select	Select		Taking	Not Taking
	CICLOPIROX	SOL 0.08	Select	Select		Taking	Not Taking
	RISPERIDON E	TAB 3MG	Select	Select		Taking	Not Taking
	TRIPLE ANTIB	OIN	Select	Select		Taking	Not Taking
	MELOXICAM	TAB 7.5MG	Select	Select		Taking	Not Taking

	ATORVASTATIN	TAB 40MG	Select	Select		Taking	Not Taking
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36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
	acetaminophen	1000 mg	PO = By Mouth	prn
	B complex	1 cap	PO = By Mouth	qd
	formula one immunity	1 cap	PO = By Mouth	qd
	Multivit	1 cap	PO = By Mouth	qd

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

comments

far sighted

Difficulty with vision

Describe

☒ Active ☐ History of ☐ Rule out

Legally Blind

☐ Yes ☒ No

Others

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ History

☒ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Other

comments

lazy right eye, no difficulty with vision in this eye

Do you wear glasses or contacts?

☒ Yes

☐ No

comments

has glasses but has not been wearing them for several years because she does not feel that she needs them and she is afraid of falling and breaking them.

Do you have trouble seeing even with glasses?

☐ Yes

☒ No

Do you have problems seeing at night?

☐ Yes

☒ No

Do you have eye pain?

☐ Yes

☒ No

Do you have problems with tearing?

☐ Yes

☒ No

Do you have a problem with dry eye?

☐ Yes

☒ No

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

☐ Yes

☒ No

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

☐ Acute Upper Respiratory Infection

☒ Asthma

☐ Chronic Pulmonary Embolism

☐ Chronic Respiratory Failure

☐ Chronic Sputum Production

☐ COPD

☐ Cystic Fibrosis

☐ Hypoventilation secondary to Obesity

☐ Hypoxemia

☐ Pneumonia

☐ Pulmonary Fibrosis

☐ Respirator Dependence/ Tracheostomy Status

☐ Respiratory Arrest

- ☐ Sarcoidosis
- ☐ Sleep Apnea
- ☐ Other

Asthma

Describe

- ☐ Active
- ☒ History of
- ☐ Rule out

Supported by

- ☐ Wheezing
- ☐ Chronic Cough
- ☐ Cyanosis
- ☐ Use of Bronchodilator
- ☐ Use of Inhaled or oral steroids
- ☐ Use of ventilator
- ☐ Other

comments

none but she does report having SOB with climbing stairs

Is patient on controller medications

- ☐ Yes
- ☒ No

Does patient use rescue medications

- ☐ Yes
- ☒ No

Does patient have current exacerbation

- ☐ Yes
- ☒ No

Use of Oxygen

- ☐ Yes
- ☒ No

Shortness of breath

- ☒ Yes
- ☐ No

comments

when climbing stairs

Wheezing

- ☐ Yes
- ☒ No

Chronic Cough

- ☐ Yes
- ☒ No

Patient requires durable medical equipment

- ☐ Yes
- ☒ No

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

- ☒ Yes
- ☐ No

Diagnoses

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

Hyperlipidemia

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ Lab results
- ☒ Medication
- ☐ Other

comments

atorvastatin

↳ Is patient on Statin

☒ Yes

☐ No

Hypertension

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☐ Physical Exam

☒ Medications

☐ Symptoms

☐ Other

comments

lisinopril, spirinolactone, nifedipine

↳ Adequately controlled

☒ Yes

☐ No

☐ UnKnown

History of Chest Pain

☐ Yes

☒ No

History of Intermittent Claudication

☐ Yes

☒ No

Implanted Pacemaker

☐ Yes

☒ No

Implanted Defibrillator

☐ Yes

☒ No

Do you have abnormal heart beats?

☐ Yes

☒ No

Does your heart race?

☐ Yes

☒ No

Do you sleep on more then one pillow?

☐ Yes

☒ No

have you ever have fluid in your lungs?

☐ Yes

☒ No

Do your legs or ankles swell up?

☒ Yes

☐ No

Do you follow a special diet?

☐ Yes

☒ No

comments

does not follow a special diet but has made dietary changes including more vegetables

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

- ☐ Alcohol Dependence

☐ Bipolar Disorder

☐ Cerebral Palsy

☐ Dementia

☐ Drug Dependence

☒ Generalized Anxiety Disorder

☐ Hemiparesis

☒ Insomnia

☐ Migraine Headaches

☐ Muscular Dystrophy

☐ Parkinson's disease

☐ Restless leg syndrome

☐ Seizure Disorder

☐ Stroke

☐ TIA

☐ Other
- ☐ Amyotrophic Lateral Sclerosis

☐ Cerebral Hemorrhage

☐ Delusional Disease

☒ Depression

☐ Fibromyalgia

☐ Guillain-Barre Disease

☐ Huntington's Chorea

☐ Intellectual and or Developmental Disability

☐ Multiple Sclerosis

☐ Myasthenia Gravis

☐ Peripheral Neuropathy

☐ Schizophrenia

☐ Spinal Cord Injury

☐ Subdural Hematoma

☐ Traumatic Brain Injury

Depression

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Symptoms

☐ PHQ 2 / 9

☒ Use of antidepressant medication

☐ Other

comments

sertraline

Major

☒ Yes

☐ NO

Supported by

☐ PHQ 9

☐ Hospitalization

☒ Chronic use of antidepressant medication beyond 6 months

☐ Use of ECT

Generalized Anxiety Disorder

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Symptoms

☐ GAD 7

☒ Antianxiety

medication

☐ Other

comments

risperadone, buspirone

Insomnia

☐ Describe

☒ Active

☐ History Of

☐ Rule out

☐ Supported by

☒ Medication

☐ Symptoms

☐ History

☐ Other

comments

trazadone PRN and risperadone

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

comments

legs due to knee pain and right foot

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**

comments

risperadone, trazadone

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

comments

pt states that her depression is currently worse because of her living environment

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**

comments

has this symptoms everyday for brief periods throughout the day. This is unchanged for her and she states this is her baseline.

Feeling down, depressed or hopeless at times?

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

comments

has this symptoms everyday for brief periods throughout the day. This is unchanged for her, she states this is her baseline.

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

14

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

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

☐ Abductor lurch

☐ Ataxic

☐ Limp

☐ Paretic

☐ Other (Findings may also apply to Musculoskeletal diagnoses)

☐ Wide based

☐ Shuffling

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

☐ Yes

☒ No

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

☐ Systemic Lupus Erythematosus

☐ Tinea Pedis

☒ Other

Osteoarthritis

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Symptoms

☐ Physical Findings

☐ Image studies

☐ Other

Which joints

comments

both knees

Other

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☐ History

☒ **Symptoms**

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Other

comments

right foot pain

History / Finding of non- extremity Fracture

☐ Yes

☒ **No**

History / Finding of Hip Fracture / Dislocation

☐ Yes

☒ **No**

History / Finding of Vertebral Fracture

☐ Yes

☒ **No**

Do you have any swelling of your joints?

☐ Yes

☒ **No**

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

☒ **Yes**

☐ No

Do you have pain in your joints?

☒ **Yes**

☐ No

Do you have a problem straightening any joints?

☐ Yes

☒ **No**

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

☒ **Yes**

☐ No

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

☐ Yes

☒ **No**

Do you have constant pain in your bones?

☐ Yes

☒ **No**

Have you had an amputation?

☐ Yes

☒ **No**

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

☐ Yes

☒ **No**

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

Describe

- ☐ Active
- ☒ History of
- ☐ Rule out
- ☐ Physical findings
- ☐ Hospitalization
- ☐ Treatments
- ☐ Lab tests
- ☐ Imaging studies
- ☒ Surgery
- ☐ Biopsy
- ☐ Other

Type

- ☐ Brain
- ☒ Breast
- ☐ Neck
- ☐ Stomach
- ☐ Lung
- ☐ Esophagus
- ☐ Colon
- ☐ Liver
- ☐ Pancreas
- ☐ Bladder
- ☐ Rectum
- ☐ Kidney
- ☐ Prostate
- ☐ Ovaries
- ☐ Uterus
- ☐ Lymph Nodes
- ☐ Bone
- ☐ Blood
- ☐ Skin
- ☐ Other

Specific type/s

left breast cancer, s/p mastectomy. Did not get chemo or radiation, takes Letrozole currently

Stage or Classification specific to the cancer

unknown

Active treatment

- ☒ Yes
- ☐ No
- ☐ Active treatment
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Stem Cell
- ☐ Bone Marrow
- ☐ Surgery
- ☐ Immune System

Other

Other

Describe
takes letrozole

Side effects

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Anemia
- ☐ Neutropenia
- ☐ Thrombocytopenia
- ☐ Weakness
- ☐ Loss of appetite
- ☐ Other

comments

none

History / Finding of Metastasis

- ☐ Yes
- ☒ No

Do you see a specialist?

- ☒ Yes
- ☐ No

Provider

Dr. Cirenza

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

pain in knees making it difficult to walk

Do you take Methadone

☐ Yes ☒ No

What drug/s do you take for it

acetaminophen

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

0/10 sitting, 6/10 when walking prolonged time.

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
146 (mmHG)	86 (mmHG)	76 (bpm)	12	98.3	95	0/10

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	4 (Inch)	190 (lbs)	32.6

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

Exam Review

Constitutional

General appearance:	Normal	Abnormal
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Head and Face

Examination of head and face:	Normal	Abnormal
Palpation of the face and sinuses:	Normal	Abnormal

Eyes

Inspection of conjunctiva and lids:	Normal	Abnormal
Examination of pupils and irises:	Normal	Abnormal

Comment: right eye deviated medially

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

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

Lymphatic

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

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
Inspection/palpation of digits and nails:	Normal	Abnormal

Comment:

great toe on right foot slightly adducted with boney prominence on the medial side.

Inspection/palpation of joints, bones and muscles:	Normal	Abnormal
Assessment of range of motion:	Normal	Abnormal
Assessment of stability:	Normal	Abnormal
Assessment of muscle strength/tone:	Normal	Abnormal

Skin

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

Neurologic

Indicate specific cranial nerve tested

II: visual acuity
III: EOM intact
IV: EOM intact
V: sensation intact to light touch on face
VI: unable to move eye laterally
VII: symmetric eye closing, symmetric facial movement
VIII: hearing intact on gross exam
X: uvula midline
XI: shoulder shrugs equal bilaterally
XII: full ROM with tongue

Indicate cranial nerve deficits found

VI- right eye does not tract past midline/laterally

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

Diabetes

Foot Exam:	Normal	Abnormal
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☒ RFoot

☐ LFoot

☐ Bilateral

Comments: great toe on right foot slightly adducted with boney prominence on the medial side. Sensation intact, no skin breakdown noted.

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	Select	Select			Select				
HBA1C	Select	Select			Select				
MICROALBUMIN	Select	Select			Select				
FOBT	Yes	Left Kit	330013419	330013419	Yes				colon cancer screening
DEXA	N/A	Select			Select				
PAD	Select	Select			Select				
LDL	No	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 : 1

Person's Answers: **banana, sunrise,**

Word Recall :	2 Points	1 point for each word spontaneously recalled without cueing. Home Safety Yes
Clock Draw :	2 Points	Normal clock = 2 points. A normal clock has all numbers placed in the correct positions) with no missing or duplicate numbers. Hands are pointing to the 11 sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor Inability or refusal to draw a clock (abnormal) = 0 points.and 2 (11:10). Hand length is not scored.
Total Score :	4 Points	Total score = Word Recall score + Clock Draw score. A cut point of < 3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of < 4 is recommended as it may indicate a need for further evaluation of cognitive status.

Home Safety & Personal Goals

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

- ☒ **None**
☐ Once
 ☐ Twice
 ☐ Three times
 ☐ More than three times

41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?	Yes	No
b. Do you have electrical cords running across floors, in doorways or under a rugs?	Yes	No
c. Do you have no slip mats on the shower floor or bath tub?	Yes	No
d. Do have adequate lighting in hallways and on the stairs?	Yes	No
e. Do you have handrails on staircases?	Yes	No
f. Is your hot water heater set for a maximum of 120 degrees?	Yes	No

Comment: unknown

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

less anxiety

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

read more

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 :


Face to Face visit was completed. Pt was identified with name and date of birth. Pt had Covid prescreening call. Today patient denied symptoms of cough, shortness of breath or fever and they have not been exposed to anyone who tested + for Covid or anyone with Covid symptoms. Pt verbally provided their height and weight. Any blanks left in this assessment were unable to be completed during this assessment today.

Pt reports that she is having difficulty with house work due to pain in her knees. Has been seen by Ortho for her right foot and a brace has been ordered.

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 :	2021-04-26T09:00
Time exam finished	2021-04-26T11:00
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Provider Signature	

	<div><div>Jennifer Edwards</div><div></div><div>Digitally signed by Jennifer E Edwards, AGNP 2021-04-26, 11:17</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?