

HRA Form

Health Plan :	Optima Health
Member Name :	CHRISTOPHE R HAYES
Evaluator Name :	Candace Hembrick , FNP
Assessment Type :	Health Risk Assessment
DOB :	1971-06-16
Evaluation Date :	2021-5-1 02:00 PM
Visit Type :	Virtual: Video & Audio Capability

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	CHRISTOPHE R HAYES
Gender	Male
Address	614 LOMBARDY ST
City	SOUTH HILL
State	VA
Zip	23970
Date of Birth	1971-06-16
Age(as of date)	50
Marital Status	Single
Member Identification Number	900038422*01
HICN	
Phone Number	434/774-4454
Cell Number	434/774-4454
Alternate Contact Number	
Email	
Emergency Contact	Charlie Northington
Phone Number	804-683-9560
Primary Care Physician	MICHIE, DAVID W MD
Phone Number	434/584-2025
PCP Address	514 W ATLANTIC ST
PCP City	SOUTH HILL
PCP State	VA

PCP Zip	23970
PCP County	MECKLENBURG
Office ID	210251
Office Name	South Hill Family Medicine

### 1. Race

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

### 2. Preferred language

- |  |                                |
|--|--------------------------------|
| <input checked="" type="checkbox"/> <b>English</b> | <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 checked="" type="checkbox"/> <b>Completed 8th grade</b> |
| <input 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

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

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

9. Where do you currently live?

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

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

- ☒ **Yes**      ☐ No

11. Who do you currently live with?

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

12. Are you currently a caregiver for someone?

- ☐ Yes      ☒ **No**

13. Tobacco use

- ☐ Current      ☐ Former      ☒ **Never**

14. Alcohol Use

- ☐ Current      ☐ Former      ☒ **Never**

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

- ☐ Yes      ☒ **No**

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

### 21. Are you currently seeing any specialists?

☒ Yes
 ☐ No

Medical Specialty	Specialist	For
Podiatrist	Dr. Person	nails
Pulmonologist	Dr. Cheveron	sleep apnea
Cardiologist	Dr. Delingle	heart
Allergist / Immunologist	Dr. Bloomburg	allergies
Gastroenterologist	Dr. Gilliam	stomach
Ophthalmologist	Dr. Brown	eye doctor

### 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

### 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

comments patient was adopted and does not know his 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	Yes
If Diabetic Eye Exam	Yes
If Diabetic Foot Exam	Yes
If Diabetic Hgb A1c screen	Yes
Lipid Panel	Yes

### 28. Last colonoscopy if more than 2 years ago

- ☐ 3 – 5 years ago
 ☐ 6 – 10 years ago
 ☐ > 10 years ago
 ☒ **Never**
☐ Don't know

### 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
Sulfur	itch
Cipro & Clindamycin	shortness of breath
Penicillin	rash
Doxycycline	light headed
Indometric	sneezing, coughing, increased mucous

### Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status
-----------	------------	--------------	-------	-----------	-----------------------	--------

2021-05-01	METFORMIN TAB	500MG	PO = By Mouth	QD		Taking	Not Taking
2021-05-01	FAMOTIDINE TAB	20MG	PO = By Mouth	QPM		Taking	Not Taking
2021-05-01	SPIRONOLAC T TAB	25MG	PO = By Mouth	QD		Taking	Not Taking
2021-05-01	LOSARTAN POT	TAB 100MG	PO = By Mouth	QPM		Taking	Not Taking
2021-05-01	LORATADINE TAB	10MG	PO = By Mouth	PRN		Taking	Not Taking
2021-05-01	ALLOPURINO L TAB	100MG	PO = By Mouth	QD		Taking	Not Taking
2021-05-01	BUPROPION TAB	75MG	PO = By Mouth	BID		Taking	Not Taking
2021-05-01	ALBUTEROL AER	HFA	PO = By Mouth	PRN		Taking	Not Taking
2021-05-01	ESOMEPRA MAG	CAP 40MG DR	PO = By Mouth	BID		Taking	Not Taking
2021-05-01	VITAMIN D	TAB 2000UNIT	PO = By Mouth	QD		Taking	Not Taking
2021-05-01	MUCUS RELIEF Mucinex	TAB 1200MG	PO = By Mouth	QD		Taking	Not Taking
2021-05-01	AMLODIPINE TAB	10MG	PO = By Mouth	QD		Taking	Not Taking
2021-05-01	TRIAMCINOL ON CRE	0.025%	T = Topical	PRN		Taking	Not Taking
2021-05-01	CARVEDILOL TAB	25MG	PO = By Mouth	QD		Taking	Not Taking
2021-05-01	MUPIROCI N OIN	2%	T = Topical	PRN		Taking	Not Taking
2021-05-01	SUCRALFATE SUS	1GM/10ML	PO = By Mouth	QID		Taking	Not Taking
2021-05-01	AZELASTINE SPR	0.1%	N = Nasal	QD		Taking	Not Taking
2021-05-01	CLOBETASOL CRE	0.05%	T = Topical	PRN		Taking	Not Taking
2021-05-01	FUROSEMIDE TAB	20MG	PO = By Mouth	QD		Taking	Not Taking
2021-05-01	ATORVASTAT IN TAB	40MG	PO = By Mouth	QPM		Taking	Not Taking
2021-05-01	FLUTICASON E SPR	50MCG	N = Nasal	QD		Taking	Not Taking
2021-05-01	NITROGLYCE RN SUB	0.4MG	PO = By Mouth	PRN		Taking	Not Taking
2021-05-01	BUDESONIDE SUS	32MCG	PO = By Mouth	PRN		Taking	Not Taking
2021-05-01	Trulicity	0.75mg/5mL	SQ = Subcutaneou s	QW		Taking	Not Taking
	METFORMIN	TAB 500MG	Select	Select		Taking	Not Taking
	CLOBETASOL	CRE 0.0005	Select	Select		Taking	Not Taking
	HYDROXYZ HCL	TAB 10MG	Select	Select		Taking	Not Taking

	CETIRIZINE	TAB 10MG	Select	Select		Taking	Not Taking
	ALLOPURINOL	TAB 100MG	Select	Select		Taking	Not Taking
	FUROSEMIDE	TAB 20MG	Select	Select		Taking	Not Taking
	ALBUTEROL	AER HFA	Select	Select		Taking	Not Taking
	DOXYCYCLINE	TAB 100MG	Select	Select		Taking	Not Taking
	SUCRALFATE	SUS 1GM/10ML	Select	Select		Taking	Not Taking
	LORATADINE	TAB 10MG	Select	Select		Taking	Not Taking
	AZELASTINE	SPR 0.001	Select	Select		Taking	Not Taking
	SPIRONOLACT	TAB 25MG	Select	Select		Taking	Not Taking
	MUPIROCIN	OIN 0.02	Select	Select		Taking	Not Taking
	AMLODIPINE	TAB 10MG	Select	Select		Taking	Not Taking
	VITAMIN D3	CAP 50MCG	Select	Select		Taking	Not Taking
	BUPROPION	TAB 75MG	Select	Select		Taking	Not Taking
	ALCOHOL PREP	PAD 0.7	Select	Select		Taking	Not Taking
	CARVEDILOL	TAB 25MG	Select	Select		Taking	Not Taking
	TRIAMCINOLON	CRE 0.005	Select	Select		Taking	Not Taking
	MUCUS RELIEF	TAB 1200MG	Select	Select		Taking	Not Taking
	AZITHROMYCIN	TAB 250MG	Select	Select		Taking	Not Taking
	PREDNISONE	TAB 20MG	Select	Select		Taking	Not Taking
	LOSARTAN POT	TAB 100MG	Select	Select		Taking	Not Taking
	FAMOTIDINE	TAB 20MG	Select	Select		Taking	Not Taking
	ESOMEPRAMAG	CAP 40MG DR	Select	Select		Taking	Not Taking
	LEVOCETIRIZI	TAB 5MG	Select	Select		Taking	Not Taking
	TRULICITY	INJ 0.75/0.5	Select	Select		Taking	Not Taking
	NASAL ALLRGY	SPR 55MCG/AC	Select	Select		Taking	Not Taking
	ATORVASTATIN	TAB 40MG	Select	Select		Taking	Not Taking
	NITROGLYCERN	SUB 0.4MG	Select	Select		Taking	Not Taking
	ERYTHROMYCIN	OIN OP	Select	Select		Taking	Not Taking
	BACLOFEN	TAB 10MG	Select	Select		Taking	Not Taking
	VITAMIN D	TAB 2000UNIT	Select	Select		Taking	Not Taking
	TRUE METRIX	KIT METER	Select	Select		Taking	Not Taking
	ONETOUCH	TES ULTRA	Select	Select		Taking	Not Taking
	FLUTICASON	SPR 50MCG	Select	Select		Taking	Not Taking



	E						
	CYCLOBENZ APR	TAB 10MG	Select	Select		Taking	Not Taking
	CLINDAMYC IN	CAP 300MG	Select	Select		Taking	Not Taking
	BUDESONID E	SUS 32MCG	Select	Select		Taking	Not Taking

### 36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
05-01-2021	Aspirin	81mg	PO = By Mouth	daily
05-01-2021	Aleve	2 tablets	PO = By Mouth	PRN arthritis
05-01-2021	Tylenol	1000mg	PO = By Mouth	PRN muscle spasms

### 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

#### Cataracts

#### Describe

☒ Active ☐ History of ☐ Rule out

↳ Supported by

- |   |                                       |  |
|---|---------------------------------------|--|
| <input checked="" type="checkbox"/> History | <input type="checkbox"/> Symptoms     | <input type="checkbox"/> Physical Findings |
| <input type="checkbox"/> Medications        | <input type="checkbox"/> Test results | <input type="checkbox"/> Image studies     |
| <input type="checkbox"/> Biopsy             | <input type="checkbox"/> DME          | <input type="checkbox"/> Other             |

comments states that the doctor told him that it not bad enough to operate on - Dr. Brown

↳ Secondary to Diabetes

- |   |                             |
|---|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|-----------------------------|

Difficulty with vision

↳ Describe

- |  |                                     |                                   |
|--|-------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|--|-------------------------------------|-----------------------------------|

comments wears his glasses when needed. Not sure if he is near or far sited.

↳ Legally Blind

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

Do you wear glasses or contacts?

- |   |                             |
|---|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|-----------------------------|

↳ Do you have trouble seeing even with glasses?

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

Do you have problems seeing at night?

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

Do you have eye pain?

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

Do you have problems with tearing?

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

Do you have a problem with dry eye?

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

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

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

Nose Problems (Nose Bleeds, Sinus infections, Other)

- |   |                             |
|---|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|-----------------------------|

↳ Diagnoses

- |  |   |
|--|---|
| <input type="checkbox"/> Chronic Post Nasal Drip | <input type="checkbox"/> Nose Bleeds      |
| <input type="checkbox"/> Sinus Infections        | <input checked="" type="checkbox"/> Other |

Other

↳ Describe

- |  |                                     |                                   |
|--|-------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|--|-------------------------------------|-----------------------------------|

↳ Supported by

- |   |  |  |
|---|--|--|
| <input checked="" type="checkbox"/> History | <input checked="" type="checkbox"/> Symptoms | <input type="checkbox"/> Physical Findings |
| <input type="checkbox"/> Medications        | <input type="checkbox"/> Test results        | <input type="checkbox"/> Image studies     |
| <input type="checkbox"/> Biopsy             | <input type="checkbox"/> DME                 | <input type="checkbox"/> Other             |

↳ Other

comments seasonal allergies - taking Loratidine, Azelastine, and Fluticasone  
When needed he uses Mucinex

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

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

## Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes ☒ No

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

☒ Yes ☐ No

### Diagnoses

- |   |  |
|---|--|
| <input type="checkbox"/> Acute Pulmonary Embolism                   | <input type="checkbox"/> Acute Upper Respiratory Infection |
| <input checked="" type="checkbox"/> <b>Asthma</b>                   | <input type="checkbox"/> Chronic Pulmonary Embolism        |
| <input type="checkbox"/> Chronic Respiratory Failure                | <input type="checkbox"/> Chronic Sputum Production         |
| <input checked="" type="checkbox"/> <b>COPD</b>                     | <input type="checkbox"/> Cystic Fibrosis                   |
| <input type="checkbox"/> Hypoventilation secondary to Obesity       | <input type="checkbox"/> Hypoxemia                         |
| <input type="checkbox"/> Pneumonia                                  | <input type="checkbox"/> Pulmonary Fibrosis                |
| <input type="checkbox"/> Respirator Dependence/ Tracheostomy Status | <input type="checkbox"/> Respiratory Arrest                |
| <input type="checkbox"/> Sarcoidosis                                | <input checked="" type="checkbox"/> <b>Sleep Apnea</b>     |
| <input type="checkbox"/> Other                                      |  |

### Asthma

#### Describe

☒ **Active** ☐ History of ☐ Rule out

#### Supported by

<input type="checkbox"/> Wheezing	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Cyanosis
<input checked="" type="checkbox"/> <b>Use of Bronchodilator</b>	<input type="checkbox"/> Use of Inhaled or oral steroids	<input type="checkbox"/> Use of ventilator
<input type="checkbox"/> Other		

comments

Uses albuterol and budesonide

#### Is patient on controller medications

☐ Yes ☒ No

#### Does patient use rescue medications

☐ Yes ☒ No

#### Does patient have current exacerbation

☐ Yes ☒ No

### COPD

#### Describe

☒ **Active** ☐ History of ☐ Rule out

#### Supported by

<input type="checkbox"/> Use of accessory muscles	<input type="checkbox"/> Barrel Chest	<input type="checkbox"/> XR results
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Clubbing	<input type="checkbox"/> Decreased or prolonged breath sounds
<input type="checkbox"/> Dyspnea on exertion	<input type="checkbox"/> O2 use	<input checked="" type="checkbox"/> <b>Brinchodilator medication</b>
<input type="checkbox"/> Respirator	<input type="checkbox"/> Other	

#### Has patient been told they have Chronic Bronchitis

☒ Yes ☐ No

↳ **Has patient been told they have Emphysema**

☐ Yes ☒ **No**

↳ **Is patient on Bronchodilator**

☒ **Yes** ☐ No

↳ **Route is**

☒ **Inhaled** ☐ Nebulizer ☐ Oral

comments

Uses albuterol and budesonide

↳ **Is patient on Steroids**

☐ Yes ☒ **No**

↳ **Does patient have current exacerbation**

☐ Yes ☒ **No**

**Sleep Apnea**

↳ **Describe**

☒ **Active** ☐ History of ☐ Rule out

↳ **Supported by**

☒ **Use of CPAP** ☐ Positive sleep studies ☐ History of sleepiness during the day

☐ Heavy snoring / restlessness during sleep ☐ Other

**Use of Oxygen**

☐ Yes ☒ **No**

**Shortness of breath**

☐ Yes ☒ **No**

**Wheezing**

☐ Yes ☒ **No**

**Chronic Cough**

☐ Yes ☒ **No**

**Patient requires durable medical equipment**

☒ **Yes** ☐ No

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

☒ **Yes** ☐ No

↳ **Diagnoses**

- |   |  |
|---|--|
| <input type="checkbox"/> Abnormal Cardiac Rhythm                    | <input type="checkbox"/> Aneurysm                                |
| <input checked="" type="checkbox"/> <b>Angina</b>                   | <input type="checkbox"/> Atrial Fibrillation                     |
| <input type="checkbox"/> Cardio – Respiratory Failure / Shock       | <input type="checkbox"/> Cardiomyopathy                          |
| <input checked="" type="checkbox"/> <b>Congestive Heart Failure</b> | <input type="checkbox"/> Deep Vein Thrombosis                    |
| <input checked="" type="checkbox"/> <b>Hyperlipidemia</b>           | <input checked="" type="checkbox"/> <b>Hypertension</b>          |
| <input type="checkbox"/> Ischemic Heart Disease (CAD)               | <input checked="" type="checkbox"/> <b>Myocardial Infarction</b> |
| <input type="checkbox"/> Peripheral Vascular Disease                | <input type="checkbox"/> Pulmonary Hypertension                  |
| <input type="checkbox"/> Valvular Disease                           | <input type="checkbox"/> Other                                   |

**Angina**

↳ **Describe**

	<input type="checkbox"/> Active <input checked="" type="checkbox"/> <b>Supported by</b> <input checked="" type="checkbox"/> <b>Medications</b> <input type="checkbox"/> Other	<input checked="" type="checkbox"/> <b>History Of</b> <input type="checkbox"/> History characterizing chest pain	<input type="checkbox"/> Rule out <input type="checkbox"/> Stress test
comments	Taking Nitroglycerin when needed <input checked="" type="checkbox"/> <b>Describe</b> <input checked="" type="checkbox"/> <b>Stable</b> <b>Congestive Heart Failure</b> <input checked="" type="checkbox"/> <b>Describe</b> <input checked="" type="checkbox"/> <b>Active</b> <input checked="" type="checkbox"/> <b>Supported by</b> <input type="checkbox"/> Ejection fraction <input type="checkbox"/> DOE <input checked="" type="checkbox"/> <b>Medications</b>		
		<input type="checkbox"/> Unstable <input type="checkbox"/> History of <input type="checkbox"/> Cardiomegaly <input type="checkbox"/> PND <input type="checkbox"/> Peripheral edema	<input type="checkbox"/> Rule out <input type="checkbox"/> Orthopnea <input type="checkbox"/> S3 <input type="checkbox"/> Other
comments	Taking Furosemide and Spironolactone <input checked="" type="checkbox"/> <b>Describe</b> <input type="checkbox"/> Diastolic <input type="checkbox"/> Systolic <input checked="" type="checkbox"/> <b>Unknown</b> <input checked="" type="checkbox"/> <b>Secondary to Hypertension</b> <input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> <b>Is patient on an ACE or ARB</b> <input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No		
comments	Taking Losartan <input checked="" type="checkbox"/> <b>Is patient on a Beta Blocker</b> <input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No		
comments	Taking Carvedilol <b>Hyperlipidemia</b> <input checked="" type="checkbox"/> <b>Describe</b> <input checked="" type="checkbox"/> <b>Active</b> <input checked="" type="checkbox"/> <b>Supported by</b> <input checked="" type="checkbox"/> <b>Lab results</b>		
		<input type="checkbox"/> History of <input type="checkbox"/> Medication	<input type="checkbox"/> Rule out <input type="checkbox"/> Other
comments	Atorvastatin <input checked="" type="checkbox"/> <b>Is patient on Statin</b> <input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No <b>Hypertension</b> <input checked="" type="checkbox"/> <b>Describe</b> <input checked="" type="checkbox"/> <b>Active</b> <input checked="" type="checkbox"/> <b>Supported by</b> <input type="checkbox"/> Physical Exam <input type="checkbox"/> Other		
		<input type="checkbox"/> History of <input checked="" type="checkbox"/> <b>Medications</b>	<input type="checkbox"/> Rule out <input type="checkbox"/> Symptoms
comments	Amlodipine, Carvedilol, Furosemide, Spironolactone, Losartan <input checked="" type="checkbox"/> <b>Adequately controlled</b> <input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No <input type="checkbox"/> UnKnown <b>Myocardial Infarction</b> <input checked="" type="checkbox"/> <b>Describe</b> <input type="checkbox"/> Active (in past 28 <input checked="" type="checkbox"/> <b>History of</b>		
			<input type="checkbox"/> Rule out

- days)
- ↳ Supported by
    - ☐ ECG changes
    - ☐ Lab results
    - ☒ History of Hospitalization / Procedure for MI
    - ☐ Medications
    - ☐ Other

comments

2012

- ↳ Is patient taking a Beta Blocker
  - ☒ Yes
  - ☐ No
- ↳ Is patient taking
  - ☒ Aspirin
  - ☐ Plavix
  - ☐ Nitrate
  - ☐ Other

### History of Chest Pain

- ☒ Yes ☐ No
- ↳ Pain described as
  - ☐ Achy
  - ☒ Sharp
  - ☐ Tight
  - ☐ Crushing
- ↳ Does pain go into left arm
  - ☒ Yes
  - ☐ No
- ↳ Is pain reproduced or worsened when touching chest or costochondral junctions
  - ☐ Yes
  - ☒ No
- ↳ Is pain brought on by
  - ☐ Exertion
  - ☐ Eating
  - ☒ Stress / Anxiety
  - ☐ Other
- ↳ 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

comments

sometimes but he just had his heart checked out.

### Do you sleep on more then one pillow?

- ☒ Yes
- ☐ No

comments

3 pillows and he has blocks on his bed.

### 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

↳ Diagnoses

☐ Bowel Obstruction

☐ Celiac Disease

☐ Colon Polyps

☐ Gall Bladder Disease

☒ GERD

☐ Inflammatory Bowel Disease

☐ Ulcer Disease

☐ Cachexia

☐ Cirrhosis

☐ Diverticulitis

☐ Gastroparesis

☐ Hepatitis

☐ Pancreatitis

☒ Other

GERD

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☐ Heartburn / Dyspepsia

☐ Regurgitation

☒ Medications

☐ Other

comments

Taking Famotidine and esomeprazole

Other

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☒ History

☒ Medications

☐ Biopsy

☒ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

↳ Other

comments

diaphragmatic hernia - sliding hernia in bottom part of stomach - Sucralfate

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

### 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 type="checkbox"/> Generalized Anxiety Disorder | <input type="checkbox"/> Guillain-Barre Disease                       |
| <input type="checkbox"/> Hemiparesis                  | <input type="checkbox"/> Huntington's Chorea                          |
| <input type="checkbox"/> Insomnia                     | <input type="checkbox"/> Intellectual and or Developmental Disability |
| <input type="checkbox"/> Migraine Headaches           | <input type="checkbox"/> Multiple Sclerosis                           |
| <input type="checkbox"/> Muscular Dystrophy           | <input type="checkbox"/> Myasthenia Gravis                            |
| <input type="checkbox"/> Parkinson's disease          | <input type="checkbox"/> Peripheral Neuropathy                        |
| <input type="checkbox"/> Restless leg syndrome        | <input type="checkbox"/> Schizophrenia                                |



- ☐ Seizure Disorder
- ☐ Stroke
- ☐ TIA
- ☒ Other
- ☐ Spinal Cord Injury
- ☐ Subdural Hematoma
- ☐ Traumatic Brain Injury

Depression

Describe

- ☒ Active

Supported by

- ☐ Symptoms

- ☐ History of

- ☐ PHQ 2 / 9

- ☐ Rule out

- ☒ Use of antidepressant medication

- ☐ Other

comments

Taking Bupropion

Major

- ☒ Yes

- ☐ NO

Supported by

- ☐ PHQ 9

- ☐ Hospitalization

- ☒ Chronic use of antidepressant medication beyond 6 months

- ☐ Use of ECT

Other

Describe

- ☐ Active

- ☒ History of

- ☐ Rule out

Supported by

- ☒ History

- ☐ Symptoms

- ☐ Physical Findings

- ☐ Medications

- ☐ Test results

- ☐ Image studies

- ☐ Biopsy

- ☐ DME

- ☐ Other

Other

comments

skull fracture when he was 3 years old from a car accident and he has a metal plate in his right lobe.

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

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

☐ Apraxia

☐ Slurred

☐ Aphasic

## 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

- |   |   |
|---|---|
| <input type="checkbox"/> Collagen (Connective) Tissue Disease | <input type="checkbox"/> Degenerative Disc Disease        |
| <input type="checkbox"/> Extremity Fracture (other than Hip)  | <input checked="" type="checkbox"/> <b>Gout</b>           |
| <input type="checkbox"/> Hallux Valgus                        | <input type="checkbox"/> Hammer Toes                      |
| <input type="checkbox"/> Onychomycosis                        | <input checked="" type="checkbox"/> <b>Osteoarthritis</b> |
| <input type="checkbox"/> Osteomyelitis                        | <input type="checkbox"/> Osteoporosis                     |
| <input type="checkbox"/> Pyogenic Arthritis                   | <input type="checkbox"/> Rheumatoid Arthritis             |
| <input type="checkbox"/> Spinal Stenosis                      | <input type="checkbox"/> Systemic Lupus Erythematosus     |
| <input type="checkbox"/> Tinea Pedis                          | <input checked="" type="checkbox"/> <b>Other</b>          |

### Gout

#### Describe

☒ **Active** ☐ History of ☐ Rule out

#### Supported by

☒ **History of attacks in Foot** ☐ Lab tests ☒ **Medications**  
☐ Other

comments

Flare is has not been for 2 years now and is usually on his right great toe - Taking Allopurinol

### Osteoarthritis

#### Describe

☒ **Active** ☐ History of ☐ Rule out

#### Supported by

☐ Symptoms ☐ Physical Findings ☒ **Image studies**  
☐ Other

#### Which joints

comments

bilateral knees - may take Aleve

### Other

#### Describe

☒ **Active** ☐ History of ☐ Rule out

#### Supported by

<input checked="" type="checkbox"/> <b>History</b>	<input checked="" type="checkbox"/> <b>Symptoms</b>	<input type="checkbox"/> Physical Findings
<input type="checkbox"/> Medications	<input type="checkbox"/> Test results	<input type="checkbox"/> Image studies
<input type="checkbox"/> Biopsy	<input type="checkbox"/> DME	<input type="checkbox"/> Other

#### Other

comments

muscle spasms - upper right chest area - instead of taking the Cyclobenzaprine the doctor told him to take Tylenol 500mg (2).

## 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

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☐ History

☒ Medications

☐ Biopsy

☒ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

↳ What type

☐ Contact

☐ Disease Induced

☐ Stasis

☒ Unspecified

☐ Drug induced

comments

He states that he has random flares due to his sensitive skin. He uses Mupirocin cream, Clobetasol cream, and Triamcinolone cream

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

↳ 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"/> <b>Diabetes</b>                        |
| <input type="checkbox"/> Diabetic Retinopathy                         | <input type="checkbox"/> Secondary Hyperparathyroidism                     |
| <input 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

7.1

##### And Date

comments

last month

##### Met with a nurse or dietician for diabetic education

☐ Yes

☒ **No**

##### Met with a diabetic educator

☐ Yes

☒ **No**

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

☐ Yes

☒ **No**

Do you often feel thirsty?

☐ Yes

☒ **No**

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

☐ Yes

☒ **No**

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

☐ Yes

☒ **No**

Do you get ulcers on your legs or feet?

☐ Yes

☒ **No**

Do you feel sluggish?

☐ Yes

☒ **No**

Do you sweat a lot or constantly feel hot?

☐ Yes

☒ **No**

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

☐ Yes

☒ **No**

Have you ever had dialysis?

☐ Yes

☒ **No**

Is your skin itchy?

☐ Yes

☒ **No**

Do you test your blood sugar?

☒ Yes

☐ No

comments

Checking blood sugar every other day and yesterday it was 130.

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

Diagnoses

- ☐ AIDS

☐ C. Difficile

☐ HIV

☐ Hospital Acquired MRSA Infection

☐ Leukemia

☐ Multiple Myeloma

☐ Sickle Cell Disease

☐ Thalassemia

☐ Tuberculosis

☐ Other
- ☐ Anemia

☐ Community Acquired MRSA Infection

☐ Herpes Zoster

☐ Immune Deficiency

☐ Lymphoma

☐ Sepsis

☐ Sickle Cell Trait

☐ Thrombocytopenia

☒ Vitamin D Deficiency

Vitamin D Deficiency

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ Labs☒ Medications

☐ Other☐ History

comments

Taking Vitamin D.

Easy bruising or abnormal bleeding

☐ Yes

☒ No

Long term anticoagulation use

☒ Yes

☐ No

Describe

- ☒ Aspirin

☐ Coumadin

☐ Thrombin Inhibitors (Pradaxa)

☐ Plavix

☐ Factor Xa Inhibitors (Xarelto, Eliquis)

☐ Other

Cancer

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

Pain

Does the patient experience pain?

☐ Yes

☒ No

## Vital Signs

### Vital Signs

comments

Unable to obtain a complete set of VS due to virtual visit.

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
(mmHG)	(mmHG)	(bpm)		97.8		0

### BMI

Patients Height		Patients Weight	Calculate BMI
6 (Feet)	8 (Inch)	339 (lbs)	37.2

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

## Exam Review

### Constitutional

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

### Head and Face

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

### Eyes

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

### 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
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

Asked pt what they smelled, asked pt to read off their medications, blinking of eyes, performed fields of gaze, asked pt to

clinch teeth, shrug shoulders, swallow, stick out their tongue, smile, and move neck and extremities through ROM, asked patient to stand up, take a couple of steps forwards, backwards, and to sit back down.

## Indicate cranial nerve deficits found

No cranial nerve deficit noted

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

## Diabetes

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

## Psychiatric

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

## Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnosis	Comments
DIGITAL_RETINAL_EXAM	Select	Select			No				Unable to perform due to virtual visit
HBA1C	Select	Mail Kit Direct to member	00000000	00000000	No				Unable to perform due to virtual visit
MICROALBUMIN	Select	Mail Kit Direct to member	11111111	11111111	No				Unable to perform due to virtual visit.
FOBT	No	Mail Kit Direct to member	22222222	22222222	No				Unable to perform due to virtual visit.
DEXA	N/A	Select			Select				
PAD	Select	Mail Kit Direct to member			No				Unable to perform due to virtual

									visit.
LDL	No	Select	33333333	33333333	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.<sup>1-3</sup> 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 : 4

Person's Answers: **Finger, Nation,**

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

## Home Safety & Personal Goals

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

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

### 41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?	Yes	No
b. Do you have electrical cords running across floors, in doorways or under a rugs?	Yes	No
c. Do you have no slip mats on the shower floor or bath tub?	Yes	No

d. Do have adequate lighting in hallways and on the stairs?	Yes	No
e. Do you have handrails on staircases?	Yes	No
f. Is your hot water heater set for a maximum of 120 degrees?	Yes	No
g. Do you have smoke detectors on each level of the house and in all sleeping a rooms?	Yes	No
h. Do you have carbon Monoxide detectors on each level of the house?	Yes	No
i. Have used established an escape route in the event of fire?	Yes	No

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

No.

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

Would like to have his own house one day.

**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 :



This is a completed audio & video virtual visit. Verbal consent was received by the patient to conduct this virtual visit. Patient identity was verified by address and DOB. Palpation, percussion, and auscultation portions of the assessment were unable to be performed due to this being a virtual visit. Unable to obtain complete set of VS, during HRA visit, due to virtual visit.

Patient's significant other was present during the visit and assisted him with answering questions about his health history.

### Member Acknowledgment

I have been advised by the evaluator and understand that the services performed by the evaluator are limited to the evaluation performed today; the evaluator has no further duties to me once the evaluation performed today is completed ; the evaluator is not liable for abandonment my refusing to provide me treatment or continuing care to me beyond this evaluation; and I should contact my primary care or treating physician for all questions and concerns regarding medical care and treatment or, in the event of an emergency, call 911

Member informed of acknowledgment	<input checked="" type="checkbox"/>
-----------------------------------	-------------------------------------

Date/Time of Service/Evaluation :	2021-05-01T14:11
Time exam finished	2021-05-01T15:29
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input checked="" type="checkbox"/>
Provider Signature	  Digitally signed by Candace Hembrick , FNP 2021-05-01, 17:29
Addendum	<div></div>

## 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?