

HRA Form

| | |
|-------------------|------------------------|
| Health Plan : | Optima Health |
| Member Name : | ASHLEY D GILCHRIST |
| Evaluator Name : | Greta Bakanowski, FNP |
| Assessment Type : | Health Risk Assessment |
| DOB : | 1991-03-28 |
| Evaluation Date : | 2021-4-21 03:00 PM |
| Visit Type : | In Person |

Demographics

| | |
|------------------------------|--------------------------|
| Plan | OHP - OPTIMA |
| Program | MEDICARE |
| LOB | DSNP |
| Name | ASHLEY D GILCHRIST |
| Gender | Male |
| Address | 5420 MONTBROOK CIR APT C |
| City | RICHMOND |
| State | VA |
| Zip | 23227 |
| Date of Birth | 1991-03-28 |
| Age(as of date) | 30 |
| Marital Status | Single |
| Member Identification Number | 900039482*01 |
| HICN | |
| Phone Number | 804/729-1692 |
| Cell Number | 804/729-1692 |
| Alternate Contact Number | |
| Email | |
| Emergency Contact | MJ Williams |
| Phone Number | 804-709-2647 |
| Primary Care Physician | MCKAY, LAUREN E DO |
| Phone Number | 804/254-3500 |
| PCP Address | 2116 W LABURNUM AVENUE |
| PCP City | RICHMOND |
| PCP State | VA |

| | |
|-------------|----------|
| PCP Zip | 23227 |
| PCP County | HENRICO |
| Office ID | 10112062 |
| Office Name | |

1. Race

- ☐ Caucasian
 ☐ African American
 ☐ Asian
- ☐ Latino
 ☐ Native American
 ☐ Native Hawaiian or other Pacific Islander
- ☐ Alaskan Native
 ☒ Other
- ☐ Describe
No Ethnicity

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

12. Are you currently a caregiver for someone?

- ☒ Yes ☐ No

 Describe
two daughters

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 |
|---------------------------|------------|-----|
| Obstetrician/Gynecologist | Dr. Parker | |

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

urinary tract

| | | | | | | |
|-------------------------------------|------|---|---|---|---|-----------|
| 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

| Family Member | Medical Condition | Cause of Death |
|---------------|-------------------|----------------|
| Mother | unknown | |
| Father | unknown | |

comments

patient says she was adopted so not sure of medical problems of relatives

Preventive Care

27. In the past three years have you had?

| Screen | Answer |
|----------------------------|----------------|
| Colonoscopy | No |
| Breast Exam/Mammography | No |
| Cervical Screening | Yes |
| Bone Density | Not Applicable |
| 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 | 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**

33. Have you been vaccinated for Pneumonia?

- ☐ Yes
 ☒ **No**

34. Have you been vaccinated for Herpes Zoster?

- ☐ Yes
 ☒ **No**

Allergies / Medications

35. Allergies

- ☐ Yes
 ☒ **No**

Medications

| Diagnoses | Label Name | Dose / Units | Route | Frequency | Prescribing Physician | Status | |
|-----------|----------------|--------------|--------|-----------|-----------------------|--------|------------|
| | CEPHALEXIN CAP | 500MG | Select | Select | | Taking | Not Taking |

| | | | | | | | |
|--|----------------------|-------|--------|--------|--|--------|------------|
| | PHENAZOPYR ID TAB | 200MG | Select | Select | | Taking | Not Taking |
|--|----------------------|-------|--------|--------|--|--------|------------|

36. Over the Counter Medications / Supplements

☐ Yes ☒ No

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 |

Review of Systems and Diagnoses

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

☒ Yes ☐ No

Diagnoses

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Disease

- ☐ Difficulty with vision
- ☐ Hyperopia
- ☒ Myopia
- ☐ Others

Myopia

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Symptoms

☒ Glasses/ lenses

☐ Other

Do you wear glasses or contacts?

☒ Yes ☐ No

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

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

☐ 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

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

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 | <input checked="" type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than half the days | <input type="checkbox"/> Nearly every day |
| Feeling down, depressed or hopeless | <input checked="" type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than half the days | <input type="checkbox"/> Nearly every day |

PHQ 2 Score

- ☒ < 3 ☐ 3 or more

Speech

- ☒ Normal ☐ Slurred ☐ Aphasic
- ☐ Apraxia

Finger to Nose

- ☒ Normal ☐ Abnormal

Heel (Shin) to Toe

- ☒ Normal ☐ Abnormal

Thumb to Finger Tips

- ☒ Normal ☐ Abnormal

Sitting to Standing

- ☒ Normal ☐ Needs Assistance ☐ Unable

Facial / Extremity Movement

- ☐ Motor Tic ☐ Vocal Tic ☐ Benign (Essential Tremor)
- ☐ Intention Tremor ☐ Non-Intention (Pill rolling) ☐ Rigidity

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Spasticity | <input type="checkbox"/> Tremor | <input type="checkbox"/> Cog wheeling |
| <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Chorea Movement | |

Gait

- | | | |
|---|---|-------------------------------------|
| <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Limp | <input type="checkbox"/> Wide based |
| <input type="checkbox"/> Abductor lurch | <input type="checkbox"/> Paretic | <input type="checkbox"/> Shuffling |
| <input type="checkbox"/> Ataxic | <input type="checkbox"/> Other (Findings may also apply to Musculoskeletal diagnoses) | |

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

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

Diagnoses

- | | |
|---|--|
| <input type="checkbox"/> Acute Renal Failure | <input type="checkbox"/> BPH |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> ESRD |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Frequent UTI |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Nephritis or Nephrosis |
| <input type="checkbox"/> Urinary Incontinence | <input checked="" type="checkbox"/> Other |

Other

Describe

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

Other

comments

Patient had urinary tract infection last month, she went to emergency room and they prescribed her oral medications. She states she no longer has symptoms and that it "cleared up".

History of frequency

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

History of Nocturia

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

History of Hesitancy

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

Do you have trouble urinating?

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

Do you ever have blood in your urine?

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> 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?

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

Do you have trouble holding your urine?

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

Do you trouble getting to the bathroom on time?

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

Do you ever have pain or burning during urination?

☐ Yes ☒ No

Do you ever wear pads or diapers?

☐ Yes ☒ No

Do you have a vaginal discharge?

☐ Yes ☒ No

Do you have vaginal bleeding?

☐ Yes ☒ No

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

☒ Yes ☐ No

↳ Diagnoses

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

Other

↳ Describe

☒ Active ☐ History of ☐ Rule out

comments

CERBAL PALSY, Lumbar spine pain, ankle and knee pain, PES PLANUS LEFT FOOT, LEFT ANKLE SWELLING, KNEES VALGUS ALIGNMENT

↳ Supported by

- | | | |
|--------------------------------------|--|--|
| <input 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

lumbar spine pain without radiculopathy and without myelopathy,

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

comments

left ankle

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

comments

with prolonged standing

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 |
|---------------------|-----|----|

Pain

Does the patient experience pain?

☒ Yes ☐ No

comments

active and intermittent

Is the Pain Acute?

☐ Yes ☒ No

Is the Pain Chronic?

☒ Yes ☐ No

comments

intermittent pain with prolonged activity. Patient is housekeeper and says that she will intermittently have pain in her ankles, knees, and spine. During assessment she does have scoliotic curvature of her back as well as valgus knee alignment. She has pes planus and slightly swollen ankles . Combined likely causing poor alignment and stress on these areas.

Describe

☒ Active

☐ History of

☐ Rule out

Where

ankles, knees, lumbar spine

Do you take Methadone

☐ Yes ☒ No

↳ What drug/s do you take for it

none

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

none

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 |
|----------------|-----------|----------|------------------|------|----------------|----------------|
| 132 (mmHG) | 90 (mmHG) | 76 (bpm) | 16 | 97.6 | 97 | 0/10 |

BMI

| Patients Height | | Patients Weight | Calculate BMI |
|-----------------|----------|-----------------|---------------|
| 5 (Feet) | 7 (Inch) | 213 (lbs) | 33.4 |

☒ **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 |

Comment: ankle synovitis left, pes planus on left, valgus knee alignment, valgus left great toe, scoliosis of spine, right foot scarring dorsum of foot s/p club foot repair on right foot from childhood

| | | |
|-------------------------------------|--------|----------|
| 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: dorsum of right foot scarring

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

Neurologic

Indicate specific cranial nerve tested

II, III, IV, V, X, XI

Indicate cranial nerve deficits found

normal

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

Diabetes

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

Comment: deferred, patient is not diabetic

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 | Diagnosi s | Commen ts |
|------------------------|-----------------|--------|----------|-----------------|---------------------|-----------|------------------|------------|-----------|
| DIGITAL_ RETINAL _EXAM | Select | Select | | | Select | | | | |
| HBA1C | Select | Select | 88888888 | 88888888 | Select | | | | |
| MICROAL BUMIN | Select | Select | | | Select | | | | |
| FOBT | No | Select | | | Select | | | | |
| 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, chair

| | | |
|---------------|----------|--|
| Word Recall : | 3 Points | 1 point for each word spontaneously recalled without cueing. Home Safety Yes |
| Clock Draw : | 2 Points | Normal clock = 2 points. A normal clock has all numbers placed in the correct positions) with no missing or duplicate numbers. Hands are pointing to the 11 sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor Inability or refusal to draw a clock (abnormal) = 0 points.and 2 (11:10). Hand length is not scored. |
| Total Score : | 5 Points | Total score = Word Recall score + Clock Draw score. A cut point of < 3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of < 4 is recommended as it may indicate a need for further |

evaluation of cognitive status.

Home Safety & Personal Goals

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

- ☒ None
 ☐ 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?

I need a primary care doctor

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

I need a primary care doctor and a dentist, sometimes I have back pain when I work. I'm a housekeeper at the Westin down the street.

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 :

Patient does not have primary care doctor. Needs referral to obtain and complete regular health maintenance.

Needs to see a dentist, she has not had a dental exam in "I don't know how long".
See ophthalmology referral
It would also benefit if she were to see an orthopedist for the complaints of pes planus, scoliosis, and possible lumbar spine pain and left ankle synovitis related.

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 : | 2021-04-21T12:33 |
| Time exam finished | 2021-04-21T13:43 |
| I accept the Disclosure Statement | <input checked="" type="checkbox"/> |
| Provider Signature | <div> <div>Greta Bakanowski</div>  <div>Digitally signed by Greta Bakanowski, FNP 2021-06-08, 11:58</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?