

HRA Form

Health Plan :	Optima Health
Member Name :	ETHEL B PERROW
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1932-08-15
Evaluation Date :	2021-7-22 06:00 PM
Visit Type :	

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	ETHEL B PERROW
Gender	Female
Address	2109 HANOVER ST
City	LYNCHBURG
State	VA
Zip	24501-9998
Date of Birth	1932-08-15
Age(as of date)	89
Marital Status	Widowed
Member Identification Number	900039673*01
HICN	
Phone Number	434/841-7496
Cell Number	434/841-7496,
Alternate Contact Number	434/841-7496,
Email	
Emergency Contact	Diane Nickerson
Phone Number	4348417496
Primary Care Physician	Dr. Altman
Phone Number	
PCP Address	2323 Memorial Ave St 10
PCP City	Lynchburg
PCP State	VA

PCP Zip	24501
PCP County	
Office ID	
Office Name	Lynchburg Family Medicine

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**

she lives in a house that is next to her daughter's

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

↳ Name

Diane Nickerson

↳ Relationship

daughter

18. Do you have an Advance Directive?

☒ Yes ☐ No ☐ Don't Know

↳ Where is it kept?

refrigerator

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: bilateral lower leg amputee, has 1 leg prosthetic leg, does not have one for the other leg, uses her wheelchair most of the time

H. Going up or down stairs	No	Need Some Help	Need Total Help
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Comment: no stairs in home, has a ramp for her wheelchair

↳ How many stairs can you climb

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

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
Other	Dr Cook	wound care
Cardiologist	Dr Conda	murmur, aortic valve stenosis, pacemaker, CHF

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](#)

1) fall 2) fall

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

Comment: HH nurse for wound care to R leg

Meals on Wheels	Yes	No
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25. In the past two years have you received any of the treatments below?

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

Family History

26. Family History

☒ Yes ☐ No

Family Member	Medical Condition	Cause of Death
Father	HTN	unknown
Mother	OA	unknown
Sibling1	Ca	Ca
Sibling2	Ca	Ca
Sibling3	alzheimers	alzheimers complications

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	No
Breast Exam/Mammography	Yes
Cervical Screening	Don't Know
Bone Density	Don't Know
Prostate Exam/PSA	Not Applicable
If Diabetic Eye Exam	Yes
If Diabetic Foot Exam	Not Applicable
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

↳ Pneumovax

☐ Yes
 ☐ No
 ☒ Unknown

↳ Prevenar

☐ Yes
 ☐ No
 ☒ Unknown

34. Have you been vaccinated for Herpes Zoster?

☐ Yes
 ☒ No

comments

Not sure

Allergies / Medications

35. Allergies

☒ Yes
 ☐ No

Substance	Reaction
silvadene	rash
cipro	hives, vomiting
atenolol	rash
hydrocodone	rash
meloxicam	rash

comments

sulfa, tape --- hives

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
hyperlipidemina	SIMVASTATIN	TAB 20MG	Select	QD	pcp	Taking	Not Taking
anemia	FERROUS SULF	TAB 325MG	Select	QD	pcp	Taking	Not Taking
htn	LISINOPRIL	TAB 40MG	Select	QD	pcp	Taking	Not Taking
htn	AMLODIPINE	TAB 5MG	Select	QD	pcp	Taking	Not Taking
hx of PE	XARELTO	TAB 10MG	Select	QD	pcp	Taking	Not Taking

DM	METFORMIN	TAB 500MG ER	Select	BID	pcp	Taking	Not Taking
	DICLOFENAC	GEL 0.01	Select	Select		Taking	Not Taking
	SMZ/TMP DS	TAB 800-160	Select	Select		Taking	Not Taking
unknown	MAGNESIUM	TAB 500MG	Select	QD	pcp	Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ **Yes** ☐ **No**

Date	Description	Dose/Units	Route	Frequency
07-22-2021	tylenol arthritis	500mg	PO = By Mouth	BID
07-22-2021	calcium/vitamin D	600mg/ 2000 IU	PO = By Mouth	Daily
07-22-2021	centrum multivitamin	1 tablet	PO = By Mouth	daily
07-21-2021	stool softener	1 capsule	PO = By Mouth	daily
07-20-2021	miralax	1 capful	PO = By Mouth	every other day

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
- ↳ Supported by
 - ☒ History
 - ☐ Medications
 - ☐ Biopsy
- ↳ Secondary to Diabetes
 - ☒ Yes
- Difficulty with vision
 - ↳ Describe
 - ☒ Active
 - ↳ Legally Blind
 - ☐ Yes
- ☒ History of
 - ☐ Symptoms
 - ☐ Test results
 - ☐ DME
- ☐ Rule out
 - ☐ Physical Findings
 - ☐ Image studies
 - ☐ Other
- ☐ No
- ☐ History of
 - ☐ Rule out
- ☒ No

Do you wear glasses or contacts?

☒ Yes ☐ No

comments help for reading and distance

↳ Do you have trouble seeing even with glasses?

☐ Yes ☒ No

Do you have problems seeing at night?

☒ Yes ☐ No

comments need to make sure the lights are on

Do you have eye pain?

☒ Yes ☐ No

↳ Which Eye?

☐ Right ☐ Left ☒ Both

comments if she is straining her eyes, not wearing her glasses

Do you have problems with tearing?

☐ Yes ☒ No

Do you have a problem with dry eye?

☒ Yes ☐ No

comments PRN eye drops

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

☒ Yes ☐ No

↳ Diagnoses

☒ Difficulty with Hearing ☐ Legally Deaf
☐ Tinnitus ☐ Vertigo
☐ Other

Difficulty with Hearing

↳ Describe

☒ Active ☐ History of ☐ Rule out

Do you have trouble hearing when people talk to you?

☒ Yes ☐ No

Do you wear a hearing aid?

☒ Yes ☐ No

↳ How often do you wear it

☐ Occasionally ☐ Frequently ☒ All of the time

Do you still have trouble hearing with it?

☐ Yes ☒ No

Do you read lips?

☒ Yes ☐ No

Do you have ear pain or drainage?

☐ Yes ☒ No

Do you ever get dizzy?

☒ Yes ☐ No

Does the room spin?

☒ Yes ☐ No

Do you ever lose your balance?

☒ Yes ☐ No

Nose Problems (Nose Bleeds, Sinus infections, Other)

☐ Yes ☒ No

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

☐ Yes ☒ No

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes ☒ No

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

☒ Yes ☐ No

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Acute Pulmonary Embolism | <input type="checkbox"/> Acute Upper Respiratory Infection |
| <input type="checkbox"/> Asthma | <input checked="" type="checkbox"/> Chronic Pulmonary Embolism |
| <input type="checkbox"/> Chronic Respiratory Failure | <input type="checkbox"/> Chronic Sputum Production |
| <input type="checkbox"/> COPD | <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 type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Other | |

Chronic Pulmonary Embolism

Describe

☒ **Active** ☐ History of ☐ Rule out

Supported by

<input checked="" type="checkbox"/> History of Pulmonary Embolism	<input type="checkbox"/> Insertion of Vena Cava Filter	<input checked="" type="checkbox"/> Anticoagulation beyond six months
<input type="checkbox"/> Other		

Use of Oxygen

☐ Yes ☒ No

Shortness of breath

☒ Yes

☐ No

comments

history of

Wheezing

☐ Yes

☒ No

Chronic Cough

☐ Yes

☒ No

Patient requires durable medical equipment

☐ Yes

☒ No

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

☒ Yes

☐ No

Diagnoses

- ☐ Abnormal Cardiac Rhythm

☐ Angina

☐ Cardio – Respiratory Failure / Shock

☒ Congestive Heart Failure

☒ Hyperlipidemia

☐ Ischemic Heart Disease (CAD)

☒ Peripheral Vascular Disease

☐ Valvular Disease
- ☐ Aneurysm

☐ Atrial Fibrillation

☒ Cardiomyopathy

☐ Deep Vein Thrombosis

☒ Hypertension

☐ Myocardial Infarction

☐ Pulmonary Hypertension

☒ Other

Cardiomyopathy

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Echo

☐ Cardiac Cath

☐ Other

Secondary to Hypertension

☒ yes

☐ No

Congestive Heart Failure

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Ejection fraction

☐ Cardiomegaly

☐ Orthopnea

☐ DOE

☐ PND

☐ S3

☒ Medications

☒ Peripheral edema

☐ Other

Describe

☒ Diastolic

☐ Systolic

☐ Unknown

Secondary to Hypertension

☒ Yes

☐ No

Is patient on an ACE or ARB

☒ Yes

☐ No

Is patient on a Beta Blocker

☒ Yes

☐ No

Hyperlipidemia

Describe

<ul style="list-style-type: none"> <ul style="list-style-type: none"> Active Supported by <ul style="list-style-type: none"> Lab results Is patient on Statin <ul style="list-style-type: none"> Yes 	<ul style="list-style-type: none"> History of 	<ul style="list-style-type: none"> Rule out
Hypertension		
<ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active Supported by <ul style="list-style-type: none"> Physical Exam Other Adequately controlled <ul style="list-style-type: none"> Yes 	<ul style="list-style-type: none"> History of 	<ul style="list-style-type: none"> Rule out
Peripheral Vascular Disease		
<ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active Supported by <ul style="list-style-type: none"> Vascular studies Diminished or absent pulses History Diabetes <ul style="list-style-type: none"> Yes Describe <ul style="list-style-type: none"> Ulceration 	<ul style="list-style-type: none"> History of Claudication Amputation No Gangrene 	<ul style="list-style-type: none"> Rule out Extremity Ulcers Other
Other		
<ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active Supported by <ul style="list-style-type: none"> History Medications Biopsy Other 	<ul style="list-style-type: none"> History of Symptoms Test results DME 	<ul style="list-style-type: none"> Rule out Physical Findings Image studies Other

aortic valve stenosis, AV block, pacemaker, murmur,

History of Chest Pain

☐ Yes ☒ No

History of Intermittent Claudication

☐ Yes ☒ No

Implanted Pacemaker

☒ Yes ☐ No

Describe

- Ventricular Tachycardia
- Asystole
- Cardiac Arrest

📅 Last interrogation date
unknown

Type and ID number not available

Implanted Defibrillator

- ☐ Yes ☒ No
- Do you have abnormal heart beats?
- ☐ Yes ☒ No
- Does your heart race?
- ☐ Yes ☒ No
- Do you sleep on more than one pillow?
- ☐ Yes ☒ No
- have you ever have fluid in your lungs?
- ☐ Yes ☒ No
- Do your legs or ankles swell up?
- ☐ Yes ☒ No
- Do you follow a special diet?
- ☐ Yes ☒ No
- Do you have headaches?
- ☒ Yes ☐ No
- Do you feel light headed when you stand up?
- ☒ Yes ☐ No

comments

rare

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

- ☒ Yes ☐ No

Diagnoses

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

GERD

Describe

- ☒ Active

- ☐ History of

- ☐ Rule out

Supported by

- ☒ Heartburn /
Dyspepsia

- ☐ Regurgitation

- ☐ Medications

- ☐ Other

History of blood in stool

- ☐ Yes ☒ No

History of black stools

- ☐ Yes ☒ No

History of Heartburn / Dyspepsia

- ☒ Yes ☐ No

Describe

- ☒ Occasionally

- ☐ Chronic

comments

not taking medication daily or PRN, discussed tx when symptoms are present

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

comments

adequately controlled with medication

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

↳ If abnormal

☒ Constipation

☐ Diarrhea

☐ Bowel Incontinence

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

☐ Amyotrophic Lateral Sclerosis

☐ Cerebral Hemorrhage

☐ Delusional Disease

☒ Depression

☐ Fibromyalgia

☐ Guillain-Barre Disease

☐ Huntington's Chorea

☐ Intellectual and or Developmental Disability

☐ Multiple Sclerosis

- ☐ Muscular Dystrophy

☐ Parkinson’s disease

☐ Restless leg syndrome

☐ Seizure Disorder

☐ Stroke

☐ TIA

☐ Other
- ☐ Myasthenia Gravis

☐ Peripheral Neuropathy

☐ Schizophrenia

☐ Spinal Cord Injury

☐ Subdural Hematoma

☐ Traumatic Brain Injury

Depression

Describe

- ☒ Active

☐ History of

☐ Rule out

comments

does not need medication

Supported by

- ☒ Symptoms

☐ PHQ 2 / 9

☐ Use of antidepressant medication

- ☐ Other

Major

- ☐ 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

History of headaches

- ☒ Yes

☐ No

Symptoms with headaches of

- ☐ Visual Changes

☐ Auditory changes

☐ Nausea / vomiting

☐ Sensitivity to light / sound

☒ None

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

☐ Slurred

☐ Aphasic

☐ Apraxia

Finger to Nose

☒ Normal

☐ Abnormal

Heel (Shin) to Toe

☐ Normal

☒ Abnormal

☐ If abnormal

☐ Left

☐ Right

☒ Both

comments

bilateral lower leg amputation

Thumb to Finger Tips

☒ Normal

☐ Abnormal

Sitting to Standing

☐ Normal

☒ Needs Assistance

☐ Unable

Facial / Extremity Movement

☐ Motor Tic

☐ Vocal Tic

☐ Benign (Essential Tremor)

☐ Intention Tremor

☐ Non-Intention (Pill rolling) Tremor

☐ Rigidity

☐ Spasticity

☐ Chorea Movement

☐ Cog wheeling

☒ Normal

Gait

☐ Normal

☐ Limp

☐ Wide based

☐ Abductor lurch

☐ Paretic

☐ Shuffling

☐ Ataxic

☒ Other (Findings may also apply to Musculoskeletal diagnoses)

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

☒ Yes

☐ No

Diagnoses

☐ Acute Renal Failure

☒ Chronic Kidney Disease

☐ Erectile Dysfunction

☐ Kidney Stones

☐ Urinary Incontinence

☐ BPH

☐ ESRD

☐ Frequent UTI

☐ Nephritis or Nephrosis

☐ Other

Chronic Kidney Disease

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Lab tests

☐ Calculated GFR X 3

☐ Other

What stage

☐ 1 [GFR > 89]

☐ 2 [GFR 60-89]

☐ 3 [GFR 30-59]

☐ 4 [GFR 15-29]

☐ 5 [GFR <15]

comments

unknown

Secondary to Diabetes

☒ Yes

☐ No

Secondary to Hypertension

☒ Yes

☐ No

History of frequency

☐ Yes

☒ No

History of Nocturia

☐ Yes

☒ No

History of Hesitancy

☐ Yes

☒ No

Do you have trouble urinating?

☐ Yes

☒ No

Do you ever have blood in your urine?

☐ 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 holding your urine?

☐ Yes

☒ No

Do you trouble getting to the bathroom on time?

☐ Yes

☒ 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

☐ Collagen (Connective) Tissue Disease

☐ Degenerative Disc Disease

☐ Extremity Fracture (other than Hip)

☐ Gout

☐ Hallux Valgus

☐ Hammer Toes

- ☐ Onychomycosis
- ☐ Osteomyelitis
- ☐ Pyogenic Arthritis
- ☐ Spinal Stenosis
- ☐ Tinea Pedis

- ☒ **Osteoarthritis**
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Systemic Lupus Erythematosus
- ☒ **Other**

Osteoarthritis

Describe

- ☒ **Active**

☐ History of

☐ Rule out

Supported by

- ☒ **Symptoms**

☐ Physical Findings

☐ Image studies

- ☐ Other

Which joints

comments

bilateral hands

Other

Describe

- ☒ **Active**

☐ History of

☐ Rule out

Supported by

- ☐ History

☒ **Symptoms**

☐ Physical Findings

- ☒ **Medications**

☐ Test results

☐ Image studies

- ☐ Biopsy

☐ DME

☐ Other

Other

comments

intermittent low back 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

comments

bilateral hands intermittent

Do you have a problem straightening any joints?

☐ Yes

☒ **No**

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

☒ **Yes**

☐ No

comments

bilateral hands

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

comments

right below knee amputation, left above knee amputation

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

☒ Yes

☐ No

Diagnoses

- ☐ Basil Cell Carcinoma
- ☐ Eczema
- ☐ Skin ulcer
- ☒ Wound
- ☐ Dermatitis
- ☐ Psoriasis
- ☐ Urticarial Disease
- ☐ Other

Wound

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

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

Etiology

- ☒ Surgical
- ☐ Traumatic
- ☐ Burn

Do you have ulcers or wounds that require dressings?

☒ Yes

☐ No

comments

R lower leg amputation site- has been receiving wound care- managed with cream and dressing

Do you have a chronic skin condition?

☒ Yes

☐ No

comments

actinic keratosis

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

- ☒ Chronic Kidney Disease secondary to Diabetes
- ☐ Cushing’s Disease
- ☐ Diabetic Retinopathy
- ☐ Hypertension and Diabetes
- ☐ Hypothyroidism
- ☐ Peripheral Neuropathy secondary to Diabetes
- ☐ Hyperparathyroidism
- ☐ Coronary Artery Disease and Diabetes
- ☒ Diabetes
- ☐ Secondary Hyperparathyroidism
- ☐ Hyperthyroidism
- ☐ Kidney Stone
- ☒ Peripheral Vascular Disease secondary to Diabetes
- ☐ Other

Chronic Kidney Disease secondary to Diabetes

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ Decreased GFR
- ☐ Albuminuria
- ☐ Elevated BUN/ Creatinine

☐ Dialysis ☐ Other

comments lab work? Daughter could not be more specific about which labs

↳ Patient on ACE or ARB

☒ Yes ☐ No

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 7.6

↳ And Date

comments 3/8/21

↳ Met with a nurse or dietician for diabetic education

☐ Yes ☒ No

↳ Met with a diabetic educator

☐ Yes ☒ No

Peripheral Vascular Disease secondary to Diabetes

↳ Describe

☒ Active ☐ History of ☐ Rule out

↳ Supported by

☐ Physical exam ☐ Vascular studies ☐ Skin lesions

☐ Foot deformity ☐ Surgical procedures ☐ Intermittent claudication

☒ Other

Other

↳ Describe

comments bilateral lower leg amputation

↳ Patient sees Podiatrist

☐ 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

comments

CKD- no dialysis

Have you ever had dialysis?

☐ Yes

☒ No

Is your skin itchy?

☐ Yes

☒ No

Do you test your blood sugar?

☒ 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

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

Anemia

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Lab tests

☐ Symptoms

☐ History of blood transfusion

☐ Other

Etiology

☒ Iron deficiency

☐ Pernicious

☐ Kidney disease

☐ Hemolysis

☐ Aplastic

☐ Chemotherapy

☐ Blood loss

☐ Chronic Disease

☐ Folate Deficiency

☐ Other

If yes, Patient on

☒ Iron

☐ B 12

☐ Folic Acid

☐ Blood Transfusions

☐ Other

Vitamin D Deficiency

Describe

☒ Active

☐ History of

☐ Rule out

☒ Supported by

☐ Medications

☐ History

☐ Labs

☐ Other

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

Pain

Does the patient experience pain?

☒ Yes

☐ No

Is the Pain Acute?

☐ Yes

☒ No

Is the Pain Chronic?

☒ Yes

☐ No

☐ Describe

☒ Active

☐ History of

☐ Rule out

☐ Where

bilateral hands, phantom pain in bilateral lower legs, lower back

☐ Do you take Methadone

☐ Yes

☒ No

☐ What drug/s do you take for it

tylenol, diclofenac gel

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

no pain currently, but can get to a 10/10

Is the Patient Undergoing Pain Management Planning?

☐ Yes

☒ No

Was the patient advised regarding the potential for dependence?

☒ Yes

☐ No

Is there any evidence of Maladaptive Behavior?

Tolerance?

☐ Yes

☒ No

Withdrawal?

☐ Yes ☒ No

Increased usage over a longer period that intended?

☐ Yes ☒ No

Desire or unsuccessful effort to cut down on use?

☐ Yes ☒ No

Excess time spent in activities to obtain the substance?

☐ Yes ☒ No

Continued use despite Doctor advice or patient knowledge of habituation?

☐ Yes ☒ No

Physical or Psychological Problem related to the substance use?

☐ Yes ☒ No

Vital Signs

Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
(mmHG)	(mmHG)	(bpm)	16			0/10

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	0 (Inch)	111 (lbs)	21.7

- ☐ 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

Comment: unable to perform, virtual appt

Eyes

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

Ears, Nose, Mouth and Throat

External Inspection of ears and nose:	Normal	Abnormal
Otoscopic examination:	Normal	Abnormal
Comment: unable to perform, virtual appt		
Assessment of hearing:	Normal	Abnormal
Comment: needed some things repeated during the exam, difficult to say if it was the internet connection or typical		
Inspection of nasal mucosa, septum and trubينات:	Normal	Abnormal
Comment: unable to perform, virtual appt		
Inspection of lips, teeth and gums:	Normal	Abnormal
Comment: missing a few teeth		
Examination of oropharynx:	Normal	Abnormal

Neck

Examination of neck:	Normal	Abnormal
Examination of thyroid:	Normal	Abnormal
Comment: unable to perform, virtual appt		

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
Percussion of chest:	Normal	Abnormal
Comment: unable to perform, virtual appt		
Palpation of chest:	Normal	Abnormal
Comment: unable to perform, virtual appt		
Auscultation of lungs:	Normal	Abnormal
Comment: unable to perform, virtual appt		

Cardiovascular

Palpation of heart:	Normal	Abnormal
Comment: unable to perform, virtual appt		
Auscultation of heart:	Normal	Abnormal
Comment: unable to perform, virtual appt		
Carotid Arteries:	Normal	Abnormal
Comment: unable to perform, virtual appt		
Abdominal Aorta:	Normal	Abnormal

Comment:

unable to perform, virtual appt

Pedal Pulses:	Normal	Abnormal
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Comment:

unable to perform, virtual appt

Examination of Arterial Pulses:	Normal	Abnormal
---------------------------------	--------	----------

Comment:

unable to perform, virtual appt

Examination of Edema / Varicosities:	Normal	Abnormal
--------------------------------------	--------	----------

Comment:

unable to perform, virtual appt

Lymphatic

Palpation of cervical nodes (neck)	Normal	Abnormal
------------------------------------	--------	----------

Comment:

unable to perform, virtual appt

Palpation of preauricular nodes (in front of the ears)	Normal	Abnormal
--	--------	----------

Comment:

unable to perform, virtual appt

Palpation of Submandibular nodes (under jaw line/chin)	Normal	Abnormal
--	--------	----------

Comment:

unable to perform, virtual appt

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
----------------------------------	--------	----------

Comment:

unable to perform, virtual appt

Inspection/palpation of digits and nails:	Normal	Abnormal
---	--------	----------

Comment:

unable to palpate

Inspection/palpation of joints, bones and muscles:	Normal	Abnormal
--	--------	----------

Comment:

unable to palpate

Assessment of range of motion:	Normal	Abnormal
Assessment of stability:	Normal	Abnormal

Comment:

unable to perform, virtual appt

Assessment of muscle strength/tone:	Normal	Abnormal
-------------------------------------	--------	----------

Comment:

unable to perform, virtual appt

Skin

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

Comment:

unable to perform, virtual appt

Neurologic

Indicate specific cranial nerve tested

able to smile, stick tongue out, puff cheeks, shrug shoulders, move head/eyes side to side and up/down

Indicate cranial nerve deficits found

n/a

Romberg Test	Normal	Abnormal
--------------	--------	----------

Comment: unable to perform, virtual appt

Examination of reflexes:	Normal	Abnormal
--------------------------	--------	----------

Comment: unable to perform, virtual appt

Examination of sensation:	Normal	Abnormal
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Comment: unable to perform, virtual appt

Coordination:	Normal	Abnormal
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Diabetes

Foot Exam:	Normal	Abnormal
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- ☐ RFoot
- ☐ LFoot
- ☒ Bilateral

Comments: bilateral lower leg amputation

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	Yes	Select			No				
HBA1C	Yes	Select			No				
MICROAL BUMIN	Yes	Select			No				
FOBT	No	Select			No				
DEXA	N/A	Select			No				

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

Comment: does not use the shower, will sit in her wheelchair and bathes from the sink

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?

" take a good bath, better vision"

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

" no i'm fine right here where I'm at"

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

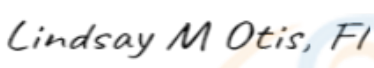
Assessors Comments :

After confirmation of patient's name and DOB a virtual visit was performed. Information was provided by the patient with assistance from her daughter. The patient was pleasant and appropriate during the visit and answered all questions. Part of the physical exam including auscultation and palpation were not able to be assessed due to the nature of a virtual visit. Inspection and direct visualization were utilized to assess appearance/normal variance. All questions were answered and they understand further communication will be provided by focus care if there are any additional questions or concerns.

Member Acknowledgment

I have been advised by the evaluator and understand that the services performed

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

Member informed of acknowledgment	<input checked="" type="checkbox"/>
Date/Time of Service/Evaluation :	2021-07-22T18:00
Time exam finished	2021-07-22T18:45
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input checked="" type="checkbox"/>
Preventative Care checklist reviewed and left with member	<input type="checkbox"/>
Provider Signature	 <div>Digitally signed by Lindsay Otis, NP 2021-07-26, 12:39</div>
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?