

HRA Form

Health Plan :	Optima Health
Member Name :	MICHELLE D YOUNG
Evaluator Name :	Jessie Cheng, FNP
Assessment Type :	Health Risk Assessment
DOB :	1966-03-07
Evaluation Date :	2021-3-30 11:30 AM
Visit Type :	Virtual: Video & Audio Capability

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	MICHELLE D YOUNG
Gender	Female
Address	23012 BANKS ROAD
City	CAPE CHARLES
State	VA
Zip	23310
Date of Birth	1966-03-07
Age(as of date)	55
Marital Status	Single
Member Identification Number	900039791*01
HICN	
Phone Number	757/607-6350
Cell Number	757/607-6350 757/360-1916
Alternate Contact Number	
Email	youngmichelle571@gmail.com
Emergency Contact	daughter - Dishae
Phone Number	757/6077202
Primary Care Physician	HOLLANDSWORTH, THOMAS MD
Phone Number	757/787-7374
PCP Address	20306 BADGER LN
PCP City	ONLEY
PCP State	VA

PCP Zip	23418
PCP County	ACCOMACK
Office ID	10216910
Office Name	Eastville Community Health Center Medical And Dental Services

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

comments

depends on her arthritis may prevent her from moving and causing pain and stiffness, poor - good

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

↳ Which drugs or medication

when she had Right knee surgery only - had popped her knee cap out of

place, surgeon reattached knee cap

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
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Comment: due to rheumatoid arthritis pain and stiffness all over her body

B. Getting in or out of chairs	No	Need Some Help	Need Total Help
--------------------------------	----	----------------	-----------------

Comment: due to rheumatoid arthritis pain and stiffness all over her body

C. Toileting	No	Need Some Help	Need Total Help
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Comment: due to rheumatoid arthritis pain and stiffness all over her body

D. Bathing	No	Need Some Help	Need Total Help
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Comment: due to rheumatoid arthritis pain and stiffness all over her body

E. Dressing	No	Need Some Help	Need Total Help
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Comment: due to rheumatoid arthritis pain and stiffness all over her body

F. Eating	No	Need Some Help	Need Total Help
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Comment: may have difficulty due to contractures in her fingers

G. Walking	No	Need Some Help	Need Total Help
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↳ How far can you walk

H. Going up or down stairs	No	Need Some Help	Need Total Help
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Comment: relies on holing onto a rail

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
Other	Rheumatologist	rheumatoid arthritis
Select	urologist	urinary incontinence

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](#)

November 2020, arthritis flared up so badly, gave her a shot - did not appear to help

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

[If one or more, describe](#)

2020 right knee surgery for her knee cap

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
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Comment: for her right knee

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: her daughter

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

Preventive Care

27. In the past three years have you had?

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

28. Last colonoscopy if more than 2 years ago

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

29. Screen for abnormal glucose / diabetes - age 40 - 70

☒ Yes ☐ No ☐ NA

30. One time screen for Abdominal Aortic Aneurysm if male with history of smoking, age 65 - 75

☐ Yes ☐ No ☒ NA

31. One time screen for Hepatitis C if born between 1945 - 1965

☐ Yes ☐ No ☒ NA

32. Do you get Flu Vaccine each year?

☒ Yes ☐ No

33. Have you been vaccinated for Pneumonia?

☐ Yes ☒ No

34. Have you been vaccinated for Herpes Zoster?

☐ Yes ☒ No

Allergies / Medications

35. Allergies

☒ Yes ☐ No

Substance	Reaction
penicillin	hives

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status
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comments methotrexate - takes 5 capsules once a week on sunday

	prednisone	5mg	PO = By Mouth	QD		Taking	Not Taking
	lasix	20mg	PO = By Mouth	QD		Taking	Not Taking
	methotrexate	2.5mg	PO = By Mouth	Select		Taking	Not Taking
	folic acid	1mg	PO = By Mouth	QD		Taking	Not Taking
	albuterol inh	puff	PO = By Mouth	QD		Taking	Not Taking
	advair	puff	PO = By Mouth	QD		Taking	Not Taking
	HYDROCO/ APAP TAB	5-325MG	Select	Select		Taking	Not Taking
	OXYCODONE TAB	5MG	Select	Select		Taking	Not Taking
	HYDROCORT CRE	2.5%	Select	Select		Taking	Not Taking
	CIPROFLOX CN TAB	250MG	Select	Select		Taking	Not Taking
	OXYBUTYNIN TAB	10MG ER	Select	Select		Taking	Not Taking
	TRAMADOL HCL	TAB 50MG	Select	Select		Taking	Not Taking
	ACETAMINO PHEN	TAB 500MG	Select	Select		Taking	Not Taking
	TRAMADOL HCL	TAB 50MG	Select	Select		Taking	Not Taking
	METHOTREX	TAB 2.5MG	Select	Select		Taking	Not Taking

	ATE						
	HYDROCORT	CRE 0.025	Select	Select		Taking	Not Taking
	PREDNISON E	TAB 5MG	Select	Select		Taking	Not Taking
	CIPROFLOX ACN	TAB 250MG	Select	Select		Taking	Not Taking
	ACETAMIN	TAB 500MG	Select	Select		Taking	Not Taking
	PAIN RELIEF	TAB 500MG	Select	Select		Taking	Not Taking
	FOLIC ACID	TAB 1MG	Select	Select		Taking	Not Taking
	OXYBUTYNI N	TAB 10MG ER	Select	Select		Taking	Not Taking
	HYDROCO/ APAP	TAB 5-325MG	Select	Select		Taking	Not Taking
	OXYCODONE	TAB 5MG	Select	Select		Taking	Not Taking
	FUROSEMID E	TAB 20MG	Select	Select		Taking	Not Taking

36. Over the Counter Medications / Supplements

☐ Yes

☒ No

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

Do you wear glasses or contacts?

☒ Yes

☐ No

Do you have trouble seeing even with glasses?

☐ Yes

☒ No

comments

she is nearsighted, her glasses does contain bifocals

Do you have problems seeing at night?

☐ Yes ☒ No

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

☐ Yes ☒ No

Nose Problems (Nose Bleeds, Sinus infections, Other)

☐ Yes ☒ No

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

☐ Yes ☒ No

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"/> Asthma | <input 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 | |

Asthma

↳ Describe

☒ **Active** ☐ History of ☐ Rule out

↳ Supported by

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

↳ Is patient on controller medications

☒ Yes ☐ No

comments

advair

↳ Does patient use rescue medications

☒ Yes ☐ No

comments

albuterol inh

↳ Does patient have current exacerbation

☐ Yes ☒ No

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

comments

per member hypertension and hyperlipidemia is no longer an issue for her

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 ☐ 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
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comments

depending if her arthritis flares up

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

↳ If abnormal

☐ Left

☐ Right

☒ Both

Thumb to Finger Tips

☐ Normal

☐ Abnormal

comments

asdf

Sitting to Standing

☐ Normal

☐ Needs Assistance

☐ Unable

comments

depending on if her arthritis flares up, she was able to get up and walk around for me during the video conference, but had to scoot herself off of the couch

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 checked="" type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Other |

Urinary Incontinence

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 |

comments

is seeing a urologist, has an upcoming appointment to address the issue

Related to stress

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

Describe

- | | | |
|--|---|--|
| <input checked="" type="checkbox"/> Daily | <input type="checkbox"/> Few times a week | <input type="checkbox"/> Less than once a week |
|--|---|--|

History of frequency

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



- | | | |
|---|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> 3x / day | <input type="checkbox"/> 4x / day | <input type="checkbox"/> 5x / day |
| <input checked="" type="checkbox"/> >5x / day | | |

History of Nocturia

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



- | | | |
|--|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> 1x / night | <input type="checkbox"/> 2x / night | <input type="checkbox"/> 3x / night |
| <input checked="" type="checkbox"/> >=4x / night | | |

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?

☐ 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

- | | |
|---|--|
| <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 checked="" 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 |

Rheumatoid Arthritis

↳ Describe

☒ Active ☐ History of ☐ Rule out

↳ Supported by

☒ Symptoms ☐ Physical findings ☐ Lab tests
☐ Image Studies ☒ Other

Other

↳ Describe

comments

takes prednisone and methotrexate

↳ Which joints

comments

all of her joints, but her hands are the worst has contractures in her hands , for example she is unable to open a bottle water with a cap

Other

↳ Describe

☒ Active ☐ History of ☐ Rule out

↳ Supported by

☒ History ☒ Symptoms ☐ Physical Findings
☒ Medications ☐ Test results ☐ Image studies

☐ Biopsy

☐ DME

☐ Other

☒ Other

comments

edema bilateral legs, takes lasix

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

comments

left 5th toe amputation

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

☒ Diagnoses

☐ AIDS

☐ C. Difficile

☐ HIV

☐ Hospital Acquired MRSA Infection

☐ Leukemia

☒ Anemia

☐ Community Acquired MRSA
Infection

☐ Herpes Zoster

☐ Immune Deficiency

☐ Lymphoma

- ☐ Multiple Myeloma
- ☐ Sickle Cell Disease
- ☐ Thalassemia
- ☐ Tuberculosis
- ☐ Other

- ☐ 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

Easy bruising or abnormal bleeding

☒ Yes

☐ No

Long term anticoagulation use

☐ Yes

☒ No

Cancer

Diagnosis of Cancer	Yes	No
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Pain

Does the patient experience pain?

☒ Yes

☐ No

Is the Pain Acute?

☐ Yes

☒ No

Is the Pain Chronic?

☒ Yes

☐ No

Describe

☒ Active

☐ History of

☐ Rule out

Where

rheumatoid arthritis in all of her joints

Do you take Methadone

☐ Yes

☒ No

What drug/s do you take for it

prednisone and methotrexate

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

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)				10/10

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	4 (Inch)	176 (lbs)	30.2

☒ **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
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Head and Face

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

Comment: virtual visit, unable to perform

Eyes

Inspection of conjunctiva and lids:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Examination of pupils and irises:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Ears, Nose, Mouth and Throat

External Inspection of ears and nose:	Normal	Abnormal
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Otoscopic examination:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Assessment of hearing:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Inspection of nasal mucosa, septum and trubينات:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Inspection of lips, teeth and gums:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Examination of oropharynx:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Neck

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

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

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
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Percussion of chest:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Palpation of chest:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Auscultation of lungs:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Cardiovascular

Palpation of heart:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Auscultation of heart:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Carotid Arteries:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Abdominal Aorta:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Pedal Pulses:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Examination of Arterial Pulses:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Examination of Edema / Varicosities:	Normal	Abnormal
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Comment: virtual visit, unable to perform

Lymphatic

Palpation of cervical nodes (neck)	Normal	Abnormal
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Comment: virtual visit, unable to perform

Palpation of preauricular nodes (in front of the ears)	Normal	Abnormal
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Comment: virtual visit, unable to perform

Palpation of Submandibular nodes (under jaw line/chin)	Normal	Abnormal
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Comment: virtual visit, unable to perform

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
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Comment: some stiffness

Inspection/palpation of digits and nails:	Normal	Abnormal
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Comment: unable to palpate but can see that all of her fingers have contractures due to rheumatoid arthritis

Inspection/palpation of joints, bones and muscles:	Normal	Abnormal
Comment: unable to palpate but can see that all of her fingers have contractures due to rheumatoid arthritis		
Assessment of range of motion:	Normal	Abnormal
Comment: limited in her hands due to contractures of her fingers		
Assessment of stability:	Normal	Abnormal
Comment: virtual visit, unable to perform		
Assessment of muscle strength/tone:	Normal	Abnormal
Comment: virtual visit, unable to perform		

Skin

Inspection of skin and subcutaneous tissue:	Normal	Abnormal
Comment: virtual visit, unable to perform		
Palpation of skin and subcutaneous tissue:	Normal	Abnormal
Comment: virtual visit, unable to perform		

Neurologic

Indicate specific cranial nerve tested

7,11,12

Indicate cranial nerve deficits found

none in the ones tested

Romberg Test	Normal	Abnormal
Comment: virtual visit, unable to perform		
Examination of reflexes:	Normal	Abnormal
Comment: virtual visit, unable to perform		
Examination of sensation:	Normal	Abnormal
Comment: virtual visit, unable to perform		
Coordination:	Normal	Abnormal
Comment: virtual visit, unable to perform		

Diabetes

Foot Exam:	Normal	Abnormal
Comment: not a 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	Diagnosis	Comments
DIGITAL_RETINAL_EXAM	Select	Select			Select				
HBA1C	Select	Select			Select				
MICROALBUMIN	Select	Select			Select				
FOBT	Yes	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, chair**

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? the pain and stiffness from arthritis

43. Is there anything that you could do to improve your quality of life? not right now

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 :

Member's ID confirmed via name, date of birth and address.

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 :	2021-03-30T11:30
Time exam finished	2021-03-30T12:23
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input checked="" type="checkbox"/>
Provider Signature	 <div> Digitally signed by Jessie Cheng, FNP 2021-04-20, 10:34 </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?