

HRA Form

Health Plan :	Optima Health
Member Name :	TIMOTHY J SHRADER
Evaluator Name :	Windy Hundley, ANP
Assessment Type :	Health Risk Assessment
DOB :	1965-08-06
Evaluation Date :	2021-7-26 10:00 AM
Visit Type :	Virtual: Video & Audio Capability

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	TIMOTHY J SHRADER
Gender	Male
Address	114 WYE ROAD
City	WYTHEVILLE
State	VA
Zip	24382-9998
Date of Birth	1965-08-06
Age(as of date)	56
Marital Status	
Member Identification Number	900039820*01
HICN	
Phone Number	276/227-0075
Cell Number	276/227-0075, 276/783-8157,
Alternate Contact Number	276/227-0075, 276/783-8157,
Email	
Emergency Contact	Beverly Duke
Phone Number	
Primary Care Physician	TOMIAK, WILLIAM M MD
Phone Number	276/228-8686
PCP Address	1375 W RIDGE ROAD
PCP City	WYTHEVILLE
PCP State	VA

PCP Zip	24382
PCP County	
Office ID	147705
Office Name	Carilion Family Medicine Wytheville

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

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
 Relationship

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

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

E. Had Surgery	None	1	2	3	4	5 or more
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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
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Preventive Care

27. In the past three years have you had?

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

Prostate Exam/PSA	Yes
If Diabetic Eye Exam	Yes
If Diabetic Foot Exam	Yes
If Diabetic Hgb A1c screen	Yes
Lipid Panel	Yes

28. Last colonoscopy if more than 2 years ago

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

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

- ☐ Yes
 ☐ No
 ☐ NA

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

- ☐ Yes
 ☐ No
 ☐ NA

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

- ☐ Yes
 ☐ No
 ☐ NA

32. Do you get Flu Vaccine each year?

- ☒ Yes
 ☐ No

33. Have you been vaccinated for Pneumonia?

- ☒ Yes
 ☐ No
- ☐ Pneumovax
 ☐ Yes
 ☐ No
 ☒ Unknown
- ☐ Prevenar
 ☐ Yes
 ☐ No
 ☒ Unknown

34. Have you been vaccinated for Herpes Zoster?

- ☒ Yes
 ☐ No
- ☐ Zostervax
 ☐ Yes
 ☐ No
 ☒ Unknown
- ☐ Shingrex
 ☐ Yes
 ☐ No
 ☒ Unknown

Allergies / Medications

35. Allergies

- ☒ Yes
 ☐ No

Substance	Reaction
kepra	rash anxious

Medications

Diagnoses	Label	Dose /	Route	Frequency	Prescribing	Status
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	Name	Units			Physician		
	NALTREXON E	TAB 50MG	Select	Select		Taking	Not Taking
	FISH OIL	CAP 1000MG	Select	Select		Taking	Not Taking
	THEREMS-M	TAB	PO = By Mouth	QD		Taking	Not Taking
	SIMVASTATIN	TAB 10MG	PO = By Mouth	QD		Taking	Not Taking
	OMEPRAZOLE	CAP 40MG	PO = By Mouth	QD		Taking	Not Taking
	MUPIROCIN	OIN 0.02	Select	Select		Taking	Not Taking
	LISINOPRIL	TAB 2.5MG	PO = By Mouth	QD		Taking	Not Taking
	GLIPIZIDE	TAB 10MG	PO = By Mouth	BID		Taking	Not Taking
	HYDROXYZPAM	CAP 25MG	Select	Select		Taking	Not Taking
	ACETAMIN	TAB 325MG	Select	Select		Taking	Not Taking
	BUSPIRONE	TAB 15MG	PO = By Mouth	TID		Taking	Not Taking
	RISPERIDONE	TAB 0.25MG	PO = By Mouth	BID		Taking	Not Taking
	FLUOXETINE	CAP 20MG	Select	Select		Taking	Not Taking
	CLONIDINE	TAB 0.1MG	Select	Select		Taking	Not Taking
	VITAMIN C	TAB 500MG	Select	Select		Taking	Not Taking
	CINNAMON	TAB 500MG	Select	Select		Taking	Not Taking
	FLUTICASON E	SPR 50MCG	Select	Select		Taking	Not Taking
	VASELINE LIP	OIN	Select	Select		Taking	Not Taking
	CLONIDINE HCL		Select	Select		Taking	Not Taking
	HYDROXYZINE PAMOATE		Select	Select		Taking	Not Taking
	GLIPIZIDE		Select	Select		Taking	Not Taking
	VITAMIN C		Select	Select		Taking	Not Taking
	FLUOXETINE HCL		Select	Select		Taking	Not Taking
	BUSPIRONE HYDROCHLORIDE		Select	Select		Taking	Not Taking
	THEREMS-M		Select	Select		Taking	Not Taking
	MUPIROCIN		Select	Select		Taking	Not Taking
	CLONIDINE HYDROCHLORIDE		Select	Select		Taking	Not Taking
	FLUTICASON E PROPIONATE		Select	Select		Taking	Not Taking
	NALTREXONE HCL		Select	Select		Taking	Not Taking

	ACETAMINO PHEN		Select	Select		Taking	Not Taking
	BUSPIRONE HCL		Select	Select		Taking	Not Taking
	VASELINE LIP THERAPY		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

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

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

☒ Yes ☐ No

↳ Diagnoses

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

Hyperlipidemia

↳ Describe

☒ **Active**

☐ History of

☐ Rule out

↳ Supported by

☐ Lab results

☐ Medication

☐ Other

↳ Is patient on Statin

☐ Yes

☐ No

Hypertension

↳ Describe

☒ **Active**

☐ History of

☐ Rule out

↳ Supported by

☐ Physical Exam

☐ Medications

☐ Symptoms

☐ Other

↳ Adequately controlled

☐ Yes

☐ No

☐ UnKnown

History of Chest Pain

☐ Yes ☒ No

History of Intermittent Claudication

☐ Yes ☒ No

Implanted Pacemaker

☐ Yes ☒ No

Implanted Defibrillator

☐ Yes ☒ No

Do you have abnormal heart beats?

☐ Yes ☒ No

Does your heart race?

- ☐ Yes ☒ No
 Do you sleep on more 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

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

- ☐ Yes ☒ No

Bowel Movements

- ☒ Normal ☐ Abnormal

Abdominal Openings

- ☐ Yes ☒ No

Rectal Problems

- ☐ Yes ☒ No

Last Bowel Movement

- ☐ Today ☒ 1-3 days ago ☐ >3 days ago

Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)

- ☒ Yes ☐ No

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Alcohol Dependence | <input type="checkbox"/> Amyotrophic Lateral Sclerosis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Cerebral Hemorrhage |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Delusional Disease |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Drug Dependence | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Generalized Anxiety Disorder | <input type="checkbox"/> Guillain-Barre Disease |
| <input type="checkbox"/> Hemiparesis | <input type="checkbox"/> Huntington's Chorea |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Intellectual and or Developmental Disability |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Restless leg syndrome | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Subdural Hematoma |

☐ TIA

☐ Traumatic Brain Injury

☐ Other

Are you nervous, anxious, feel on the edge or often feel stressed?

☐ Yes

☐ No

Do you worry too much about different things?

☐ Yes

☐ No

Do you feel afraid that something bad might happen?

☐ Yes

☐ No

History of headaches

☐ Yes

☐ No

History of auditory hallucinations

☐ Yes

☒ No

History of visual hallucinations

☐ Yes

☒ No

History of psychotic behavior

☐ Yes

☒ No

History of episodes of delirium

☐ Yes

☐ No

Do you follow a special diet?

☐ Yes

☐ No

Do you have any weakness or deformity in your arms or legs that limits your ability to get around or do what you want to do?

☐ Yes

☐ No

Do you have trouble swallowing your food?

☐ Yes

☒ No

Do you have trouble making people understand you when you speak?

☐ Yes

☐ No

Do you have 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

Thumb to Finger Tips

☐ Normal
 ☐ Abnormal

Sitting to Standing

☐ Normal
 ☐ Needs Assistance
 ☐ Unable

Facial / Extremity Movement

- | | | |
|---|--|--|
| <input type="checkbox"/> Motor Tic | <input type="checkbox"/> Vocal Tic | <input type="checkbox"/> Benign (Essential Tremor) |
| <input type="checkbox"/> Intention Tremor | <input type="checkbox"/> Non-Intention (Pill rolling) Tremor | <input type="checkbox"/> Rigidity |
| <input type="checkbox"/> Spasticity | <input type="checkbox"/> Chorea Movement | <input type="checkbox"/> Cog wheeling |
| <input type="checkbox"/> Normal | | |

Gait

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

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

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

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

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

Endocrine Problems

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

↳ Diagnoses

- | | |
|---|--|
| <input type="checkbox"/> Chronic Kidney Disease secondary to Diabetes | <input type="checkbox"/> Coronary Artery Disease and Diabetes |
| <input type="checkbox"/> Cushing's Disease | <input checked="" type="checkbox"/> Diabetes |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Secondary Hyperparathyroidism |
| <input type="checkbox"/> Hypertension and Diabetes | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Kidney Stone |
| <input type="checkbox"/> Peripheral Neuropathy secondary to Diabetes | <input type="checkbox"/> Peripheral Vascular Disease secondary to Diabetes |
| <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Other |

Diabetes

↳ Describe

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

↳ Supported by

- | | | |
|--------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Symptoms | <input type="checkbox"/> Physical findings | <input type="checkbox"/> Lab tests |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Other | |

↳ Type

- | | | |
|---------------------------------|---------------------------------|--------------------------------------|
| <input type="checkbox"/> Type 1 | <input type="checkbox"/> Type 2 | <input type="checkbox"/> Gestational |
|---------------------------------|---------------------------------|--------------------------------------|

↳ Most recent Hb A1C, value

↳ And Date

↳ Met with a nurse or dietician for diabetic education

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

Met with a diabetic educator

☐ Yes ☐ No

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

☐ Yes ☐ No

Do you often feel thirsty?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Do you get ulcers on your legs or feet?

☐ Yes ☐ No

Do you feel sluggish?

☐ Yes ☐ No

Do you sweat a lot or constantly feel hot?

☐ Yes ☐ No

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

☐ Yes ☐ No

Have you ever had dialysis?

☐ Yes ☐ No

Is your skin itchy?

☐ Yes ☐ No

Do you test your blood sugar?

☐ Yes ☐ No

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
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Pain

Does the patient experience pain?

☐ Yes ☒ No

Vital Signs

Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
140 (mmHG)	76 (mmHG)	(bpm)				

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	6 (Inch)	146 (lbs)	23.6

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

Exam Review

Constitutional

General appearance:	Normal	Abnormal
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Head and Face

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

Eyes

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

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

Cardiovascular

Palpation of heart:	Normal	Abnormal
Auscultation of heart:	Normal	Abnormal
Carotid Arteries:	Normal	Abnormal
Abdominal Aorta:	Normal	Abnormal
Pedal Pulses:	Normal	Abnormal
Examination of Arterial Pulses:	Normal	Abnormal
Examination of Edema / Varicosities:	Normal	Abnormal

Lymphatic

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

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
Inspection/palpation of digits and nails:	Normal	Abnormal
Inspection/palpation of joints, bones and muscles:	Normal	Abnormal
Assessment of range of motion:	Normal	Abnormal
Assessment of stability:	Normal	Abnormal
Assessment of muscle strength/tone:	Normal	Abnormal

Skin

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

Neurologic

Indicate specific cranial nerve tested

Indicate cranial nerve deficits found

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

Diabetes

Foot Exam:	Normal	Abnormal
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Psychiatric

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

Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnoses	Comments
DIGITAL_RETINAL_EXAM	Yes	Select			Select				
HBA1C	Yes	Select			Select				
MICROALBUMIN	Yes	Select			Select				
FOBT	Yes	Select			Select				
DEXA	N/A	Select			Select				
PAD	Yes	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 : --

Person's Answers: --

Word Recall :	-- Points	1 point for each word spontaneously recalled without cueing. Home Safety Yes
Clock Draw :	-- 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 :	-- 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?

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

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 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 type="checkbox"/>
Date/Time of Service/Evaluation :	
Time exam finished	
I accept the Disclosure Statement	<input type="checkbox"/>
Consented to Video chat	<input type="checkbox"/>
Provider Signature	
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?