

HRA Form

Health Plan :	Optima Health
Member Name :	ROSA O TEJEDA
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1946-03-27
Evaluation Date :	2021-7-13 11:00 AM
Visit Type :	

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	ROSA O TEJEDA
Gender	Female
Address	1501 VIRGINIA AVE APT 132
City	HARRISONBURG
State	VA
Zip	22802
Date of Birth	1946-03-27
Age(as of date)	75
Marital Status	Single
Member Identification Number	900039939*01
HICN	
Phone Number	540/208-8172
Cell Number	540/208-8172
Alternate Contact Number	540/208-8172,
Email	
Emergency Contact	Lourdes Lainez/ Sister
Phone Number	540-560-5799
Primary Care Physician	Paul Johnstone, PA-C
Phone Number	540-564-7300
PCP Address	1661 South Main Street
PCP City	Harrisonburg
PCP State	VA

PCP Zip	22801
PCP County	
Office ID	
Office Name	Sentara South Main Health Center

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

comments

Spanish

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

comments

GED

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
-
- ☒ **Cigarettes**
☐ Cigars
 ☐ Chewing Tobacco
- ☐ Vaping
 ☐ Other
-
- ☐ 1 - 3 a day
 ☐ 1/2 a pack
 ☒ **1 pack**
- ☐ More than 1 pack
 ☐ Other

14. Alcohol Use

☐ Current
 ☒ **Former**
☐ Never

How many drinks	How Often
4	Week

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

☐ Yes
 ☒ **No**

16. Do you have a Healthcare Proxy?

☐ Yes
 ☒ **No**
☐ Don't Know

17. Do you have a Durable Power of Attorney?

☐ Yes
 ☒ **No**
☐ Don't Know

18. Do you have an Advance Directive?

☐ Yes
 ☒ **No**
☐ Don't Know

Within the past 12 months we worried whether our food would run out before we got money to buy more. Was that _____ for your household?

☐ Often True
 ☐ Sometimes True
 ☒ **Never True**

Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Was that _____ for your household?

☐ Often True
 ☐ Sometimes True
 ☒ **Never True**

Activities of Daily Living

19. Do you have any difficulty with the following activities?

A. Getting in or out of bed	No	Need Some Help	Need Total Help
B. Getting in or out of chairs	No	Need Some Help	Need Total Help
C. Toileting	No	Need Some Help	Need Total Help
D. Bathing	No	Need Some Help	Need Total Help
E. Dressing	No	Need Some Help	Need Total Help
F. Eating	No	Need Some Help	Need Total Help
G. Walking	No	Need Some Help	Need Total Help
H. Going up or down stairs	No	Need Some Help	Need Total Help

Medical History

20. Do you use any assistive devices? (Check device or none if no devices used)

☒ **None**

21. Are you currently seeing any specialists?

☒ **Yes**
☐ No

Medical Specialty	Specialist	For
Oncologist		Renal Cancer
Pulmonologist		Lung nodule

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

Upper abdominal pain. EGD performed. DX: chronic gastritis, diaphragmatic hernia

C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
-------------------------------------	------	---	---	---	---	-----------

If one or more, describe

above problem

D. Been in a nursing home	None	1	2	3	4	5 or more
E. Had Surgery	None	1	2	3	4	5 or more

23. Have you ever been hospitalized prior to the last 12 months?

☐ Yes ☒ No

24. In the past year have you received health services from any of the providers below:

Physical Therapist	Yes	No
Occupational Therapist	Yes	No
Dietician	Yes	No
Social Worker	Yes	No
Pharmacist	Yes	No
Speech Therapist	Yes	No
Chiropractor	Yes	No
Personal Care Worker (HHA, CNA, PCA)	Yes	No
Meals on Wheels	Yes	No

25. In the past two years have you received any of the treatments below?

Chemotherapy	Yes	No	Unknown
Catheter Care	Yes	No	Unknown
Oxygen	Yes	No	Unknown
Wound Care	Yes	No	Unknown

Regular Injections	Yes	No	Unknown
Tube Feedings	Yes	No	Unknown

Family History

26. Family History

☐ Yes ☒ No

Preventive Care

27. In the past three years have you had?

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

comments

colonoscopy approx 2 years ago

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

Allergies / Medications

35. Allergies

☒ Yes ☐ No

Substance	Reaction
Hydrocodone	GI upset, rash
Zoloft	tremors

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
Hypothyroidism	LEVOTHYROXIN	TAB 25MCG	PO = By Mouth	QD	Johnstone	Taking	Not Taking
HTN	LISINAPRIL	TAB 10MG	PO = By Mouth	QD	Johnstone	Taking	Not Taking
HLD	ROSUVASTATIN	TAB 20MG	PO = By Mouth	HS	Johnstone	Taking	Not Taking
Hypothyroid	EUTHYROX	TAB 25MCG	PO = By Mouth	QD	Johnstone	Taking	Not Taking
Hemorrhoids	PROCTO-MED	CRE HC 2.5%	R = Rectal	PRN	Johnstone	Taking	Not Taking
GERD	OMEPRAZOLE	CAP 20MG	PO = By Mouth	QD	Johnstone	Taking	Not Taking
A.R	FLUTICASON E	SPR 50MCG	N = Nasal	PRN	Johnstone	Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
07-13-2021	Tylenol	500mg	PO = By Mouth	PRN

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	Yes	No

told to you by the doctor or pharmacist?		
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 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

Diagnoses

☒ Chronic Post Nasal Drip☐ Sinus Infections

Chronic Post Nasal Drip

Describe

☒ Active☐ History of☐ Rule out

Supported by

☐ History☒ Medications☐ Biopsy

☐ Nose Bleeds☐ Other

☒ Symptoms☐ Test results☐ DME

☐ Physical Findings☐ Image studies☐ Other

comments

Flonase

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

☒ Yes☐ No

Diagnoses

☐ Bleeding Gums☒ Difficulty Swallowing

Difficulty Swallowing

Describe

☐ Active☒ History of☐ Rule out

Have you had a stroke

☐ Yes☒ No

☐ Difficulty Chewing☐ Other

comments

symptoms have resolved

FOCUSCARE

8

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

- ☐ 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

Hyperlipidemia

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Lab results

☒ Medication

☐ Other

Is patient on Statin

☒ Yes

☐ No

comments

Crestor

Hypertension

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Physical Exam

☒ Medications

☐ Symptoms

☐ Other

comments

Lisinopril

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

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 checked="" type="checkbox"/> Other |

GERD

Describe

☒ Active ☐ History of ☐ Rule out

Supported by

☒ Heartburn /
 Dyspepsia ☐ Regurgitation ☒ Medications
☐ Other

comments

Omeprazole

Other

Describe

☒ Active ☐ History of ☐ Rule out

Supported by

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

Other

comments

Chronic Gastritis. Diaphragmatic Hernia.
EGD April 2021

History of blood in stool

☐ Yes ☒ No

History of black stools

☐ Yes ☒ No

History of Heartburn / Dyspepsia

☒ Yes ☐ No

Describe

☒ Occasionally ☐ Chronic

History of Vomiting or Regurgitation

☐ Yes ☒ No

History of pain after eating

☒ Yes ☐ No

Describe

☐ Right upper quadrant ☒ Epigastric ☐ Left upper quadrant

☐ Right lower quadrant ☐ Left lower quadrant

History of Jaundice

☐ Yes ☒ No

Do you follow a special diet?

☐ Yes ☒ No

Do you have frequent abnormal abdominal pain?

☐ Yes ☒ No

Do you have intermittent nausea or vomiting?

☐ Yes ☒ No

Do you have trouble with constipation?

☐ Yes ☒ No

Does diarrhea limit your ability to get out of the room or socially?

☐ Yes ☒ No

Do you see blood in your urine?

☐ Yes ☒ No

Do you have Frequent Stomach Pain

☐ Yes ☒ No

Bowel Movements

☒ Normal ☐ Abnormal

Abdominal Openings

☐ Yes ☒ No

Rectal Problems

☒ Yes ☐ No

If yes, female

☒ Hemorrhoids ☐ Fissure ☐ Mass

comments

If yes, male

☐ Hemorrhoids ☐ Fissure ☐ Mass

☐ BPH ☐ Prostate mass

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 checked="" 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 |
| <input type="checkbox"/> TIA | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Other | |

Generalized Anxiety Disorder

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☒ **Symptoms**

☐ GAD 7

☐ Antianxiety medication

☐ 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 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
- 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

- ☒ Yes ☐ No
 Patient oriented to person
- ☒ Yes ☐ No
 Patient oriented to place
- ☒ Yes ☐ No
 Patient oriented to time
- ☒ Good ☐ Poor
 Recall
- ☒ Yes ☐ Partially ☐ No
 Patient describes recent news event

Affect
☒ Normal ☐ Abnormal

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	Not at all	Several Days	More than half the days	Nearly every day
Feeling down, depressed or hopeless	Not at all	Several Days	More than half the days	Nearly every day

PHQ 2 Score

☒ < 3

☐ 3 or more

Speech

☒ Normal

☐ Apraxia

☐ Slurred

☐ Aphasic

Finger to Nose

☐ Normal

☐ Abnormal

comments

virtual visit

Heel (Shin) to Toe

☒ Normal

☐ Abnormal

Thumb to Finger Tips

☒ Normal

☐ Abnormal

Sitting to Standing

☒ Normal

☐ Needs Assistance

☐ Unable

Facial / Extremity Movement

☐ Motor Tic

☐ Vocal Tic

☐ Benign (Essential Tremor)

☐ Intention Tremor

☐ Non-Intention (Pill rolling) Tremor

☐ Rigidity

☐ Spasticity

☐ Chorea Movement

☐ Cog wheeling

☒ Normal

Gait

☒ Normal

☐ Abductor lurch

☐ Ataxic

☐ Limp

☐ Paretic

☐ Other (Findings may also apply to Musculoskeletal diagnoses)

☐ Wide based

☐ Shuffling

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

☐ Yes

☒ No

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

☒ Yes

☐ No

↳ Diagnoses

☐ Collagen (Connective) Tissue Disease

☒ Degenerative Disc Disease

- ☐ Extremity Fracture (other than Hip)

☐ Gout
- ☐ Hallux Valgus

☐ Hammer Toes
- ☐ Onychomycosis

☐ Osteoarthritis
- ☐ Osteomyelitis

☐ Osteoporosis
- ☐ Pyogenic Arthritis

☐ Rheumatoid Arthritis
- ☐ Spinal Stenosis

☐ Systemic Lupus Erythematosus
- ☐ Tinea Pedis

☐ Other

Degenerative Disc Disease

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☒ Symptoms
- ☐ Physical Findings
- ☐ Image studies
- ☐ Medications
- ☐ Other

Normal bladder and bowel function

- ☒ Yes
- ☐ No

Site of disease

- ☐ Cervical
- ☒ Thoracic
- ☐ Lumbar
- ☐ Lumbosacral
- ☐ Other

History / Finding of non- extremity Fracture

- ☐ Yes
- ☒ No

History / Finding of Hip Fracture / Dislocation

- ☐ Yes
- ☒ No

History / Finding of Vertebral Fracture

- ☐ Yes
- ☒ No

Do you have any swelling of your joints?

- ☐ Yes
- ☒ No

Do you experience stiffness in the morning or during the day?

- ☐ Yes
- ☒ No

Do you have pain in your joints?

- ☐ Yes
- ☒ No

Do you have a problem straightening any joints?

- ☐ Yes
- ☒ No

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

- ☐ Yes
- ☒ No

Have you broken bones(fractures) in any parts of your body?

- ☐ Yes
- ☒ No

Do you have constant pain in your bones?

- ☐ Yes
- ☒ No

Have you had an amputation?

- ☐ Yes
- ☒ No

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

- ☐ Yes
- ☒ No

Endocrine Problems

- ☒ Yes
- ☐ No

Diagnoses

- ☐ Chronic Kidney Disease secondary
- ☐ Coronary Artery Disease and

- to Diabetes

☐ Cushing’s Disease

☐ Diabetic Retinopathy

☐ Hypertension and Diabetes

☒ Hypothyroidism

☐ Peripheral Neuropathy secondary to Diabetes

☐ Hyperparathyroidism

Hypothyroidism

☐ Describe

☒ Active

☐ History of

☐ Rule out

☐ Supported by

☐ Weight gain

☐ Depression

☐ Fatigue

☒ Treatment for hypothyroidism

☐ Hair changes

☐ Lab data

☐ Other

- Diabetes
- ☐ Diabetes
- ☐ Secondary Hyperparathyroidism
- ☐ Hyperthyroidism
- ☐ Kidney Stone
- ☐ Peripheral Vascular Disease secondary to Diabetes
- ☐ Other

comments

Levoxyl, Euthyroid

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
---------------------	-----	----

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☐ Physical findings

☐ Hospitalization

☒ Treatments

☐ Lab tests

☐ Imaging studies

☒ Surgery

☒ Biopsy

☐ Other

Type

☐ Brain

☐ Head

☐ Neck

☐ Breast

☐ Lung

☐ Esophagus

☐ Stomach

☐ Liver

☐ Pancreas

☐ Colon

☐ Rectum

☒ Kidney

☐ Bladder

☐ Ovaries

☐ Uterus

☐ Prostate

☐ Bone

☐ Blood

☐ Lymph Nodes

☐ Skin

☐ Other

Specific type/s

unknown

Stage or Classification specific to the cancer

unknown

Active treatment

☐ Yes

☒ No

History / Finding of Metastasis

☐ Yes

☒ No

Do you see a specialist?

☒ Yes

☐ No

Provider

Oncologist for regular follow up appointments

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

back and shoulders

Do you take Methadone

☐ Yes

☒ No

What drug/s do you take for it

Tylenol

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

2

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

comments

BP Range 100-110/70s
hr 70s

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

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	4 (Inch)	152 (lbs)	26.1

☐ 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: virtual visit

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: virtual visit

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

Comment: virtual visit

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
Percussion of chest:	Normal	Abnormal

Comment: virtual visit

Palpation of chest:	Normal	Abnormal
---------------------	--------	----------

Comment: virtual visit

Auscultation of lungs:	Normal	Abnormal
------------------------	--------	----------

Comment: virtual visit

Cardiovascular

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

Lymphatic

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

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
Comment: virtual visit		

Neurologic

Indicate specific cranial nerve tested

II-XII

Indicate cranial nerve deficits found

none

Romberg Test	Normal	Abnormal
Examination of reflexes:	Normal	Abnormal

Comment: virtual visit

Examination of sensation:	Normal	Abnormal
Comment: virtual visit		

Coordination:	Normal	Abnormal
---------------	--------	----------

Diabetes

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

Psychiatric

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

Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnosis	Comments
DIGITAL_RETINAL_EXAM	No	Select			Select				
HBA1C	No	Select			Select				
MICROALBUMIN	No	Select			Select				
FOBT	Yes	Select			Select				
DEXA	N/A	Select			Select				
PAD	No	Select			Select				
LDL	No	Select			Select				

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

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

no

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

no

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 :

Virtual visit completed. Pt's identity confirmed with name, DOB and address. Pt is a pleasant 75 year old female that lives alone. Pt reports her sister and nephew live near her and they are a good support system for her. Pt reports she has had an abnormal mammogram but no diagnosis of cancer. Pt does regular mammograms. Pt states she has an abnormal nodule on her lung, was sent to a pulmonologist and an MRI was performed but pt states this was a benign finding. Pt states she has seen the pulmonologist once and does not have to go back at this time. Pt instructed to keep immunizations up to date. Pt instructed on obtaining a Life Alert as this would allow patient to access emergency response services if she should fall or have another medical issue where she needed to call for help and was not able to access a phone. Pt instructed to keep immunizations up to date. Pt verbalized understanding of all instructions and education.

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 :	2021-07-13T11:40
Time exam finished	2021-07-13T12:45
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><div>Leslie Berryman, NP-C</div><div></div><div>Digitally signed by Leslie Berryman, FNP 2021-07-13, 22:27</div></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?