

HRA Form

Health Plan :	Optima Health
Member Name :	STEVEN W RICE
Evaluator Name :	Shante Tucker, NP
Assessment Type :	Health Risk Assessment
DOB :	1955-08-29
Evaluation Date :	2021-7-15 02:00 PM
Visit Type :	Virtual: Video & Audio Capability

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	STEVEN W RICE
Gender	Male
Address	112 MYWAY LN
City	WHITE STONE
State	VA
Zip	22578-9998
Date of Birth	1955-08-29
Age(as of date)	66
Marital Status	Married
Member Identification Number	900040027*01
HICN	
Phone Number	804/435-6978
Cell Number	804/435-6978,
Alternate Contact Number	804/435-6978,
Email	
Emergency Contact	SHARON RICE
Phone Number	8044356978/8044365049
Primary Care Physician	ASHWORTH, JOEL MD
Phone Number	804/435-2651
PCP Address	402 NORTH MAIN STREET
PCP City	KILMARNOCK
PCP State	VA

PCP Zip	22482
PCP County	
Office ID	200957
Office Name	BON SECOURS KILMARNOCK PRIMARY CARE

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
Comment: VACCINATED FOR CORONAVIRUS, J& J		
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

 Name

SHARON RICE
 Relationship
WIFE

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 ☒ Cane ☐ Walker ☒ Prosthesis
☒ Wheel Chair ☐ Bedside Commode ☐ Urinal
☐ Bed Pan ☐ Other

21. Are you currently seeing any specialists?

☒ Yes ☐ No

Medical Specialty	Specialist	For
Cardiologist		CABG, HTN
Other		SURGEON FOR LEG

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

 If one or more, describe

R.LEG, ARTERY WAS OPENED

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

Comment: INSULIN

Tube Feedings	Yes	No	Unknown
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Family History

26. Family History

☒ Yes ☐ No

Family Member	Medical Condition	Cause of Death
Father	HTN	DECEASED
Mother	NA	DECEASED

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	No
Breast Exam/Mammography	Not Applicable
Cervical Screening	Not Applicable
Bone Density	No
Prostate Exam/PSA	No
If Diabetic Eye Exam	No
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
PCN	ANAPHYLAXIS

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
	JANUVIA	TAB 100MG	PO = By Mouth	QD		Taking	Not Taking
	GABAPENTIN	CAP 600MG	PO = By Mouth	TID		Taking	Not Taking
	LOSARTAN POT	TAB 50MG	PO = By Mouth	QD		Taking	Not Taking
	FUROSEMIDE	TAB 20MG	PO = By Mouth	BID		Taking	Not Taking
	LEVEMIR	INJ FLEXTOUNC 40U	SQ = Subcutaneous	QD		Taking	Not Taking
	METOPROLOL TAR	TAB 25MG	PO = By Mouth	QD		Taking	Not Taking
	ATORVASTATIN	TAB 80MG	PO = By Mouth	QD		Taking	Not Taking
	ELIQUIS	TAB 5MG	PO = By Mouth	QD		Taking	Not Taking
	AMIODARONE	TAB 200MG	PO = By Mouth	QD		Taking	Not Taking
	CLOPIDOGREL	TAB 75MG	PO = By Mouth	QD		Taking	Not Taking
	POT CHLORIDE	TAB 10MEQ ER	PO = By Mouth	QD		Taking	Not Taking
	DULOXETINE HCL	30MG	PO = By Mouth	QOD		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 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 checked="" type="checkbox"/> Angina | <input checked="" type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Cardio – Respiratory Failure / Shock | <input checked="" type="checkbox"/> Cardiomyopathy |
| <input checked="" type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Deep Vein Thrombosis |

- ☒ **Hyperlipidemia**
- ☐ Ischemic Heart Disease (CAD)
- ☒ **Peripheral Vascular Disease**
- ☐ Valvular Disease
- ☒ **Hypertension**
- ☐ Myocardial Infarction
- ☐ Pulmonary Hypertension
- ☒ **Other**
- Angina
 - ↳ Describe
 - ☐ Active
 - ↳ Supported by
 - ☐ Medications
 - ☐ Other
 - Describe
 - ☒ **Stable**
- Atrial Fibrillation
 - ↳ Describe
 - ☒ **Active**
 - ↳ Type
 - ☐ Paroxysmal
 - ↳ Supported by
 - ☒ **Medications**
 - ☐ History
 - Is patient taking
 - ☒ **Anticoagulant**
- Cardiomyopathy
 - ↳ Describe
 - ☒ **Active**
 - ↳ Supported by
 - ☐ Echo
 - ↳ Secondary to Hypertension
 - ☐ yes
- Congestive Heart Failure
 - ↳ Describe
 - ☒ **Active**
 - ↳ Supported by
 - ☐ Ejection fraction
 - ☐ DOE
 - ☒ **Medications**
 - Describe
 - ☐ Diastolic
 - ↳ Secondary to Hypertension
 - ☐ Yes
 - ↳ Is patient on an ACE or ARB
 - ☐ Yes
 - ↳ Is patient on a Beta Blocker
- History Of
 - ☐ Rule out
- History characterizing chest pain
 - ☐ Stress test
 - ☐ Unstable
- History of
 - ☐ Rule out
 - ☒ **Chronic**
 - ☐ Unknown
- ECG
 - ☐ Symptoms
- Electric cardioversion
 - ☐ Other
- Rate controlling medication
 - ☐ Other
- History of
 - ☐ Rule out
- Cardiac Cath
 - ☐ Other
- No
 - ☐ Rule out
- History of
 - ☐ Rule out
- Cardiomegaly
 - ☒ **Orthopnea**
- PND
 - ☐ S3
- Peripheral edema
 - ☐ Other
- Systolic
 - ☐ Unknown
- No
 - ☐ No

<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Hyperlipidemia		
<input type="checkbox"/> Describe		
<input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
<input type="checkbox"/> Supported by		
<input type="checkbox"/> Lab results	<input checked="" type="checkbox"/> Medication	<input type="checkbox"/> Other
<input type="checkbox"/> Is patient on Statin		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Hypertension		
<input type="checkbox"/> Describe		
<input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
<input type="checkbox"/> Supported by		
<input type="checkbox"/> Physical Exam	<input checked="" type="checkbox"/> Medications	<input type="checkbox"/> Symptoms
<input type="checkbox"/> Other		
<input type="checkbox"/> Adequately controlled		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> UnKnown
Peripheral Vascular Disease		
<input type="checkbox"/> Describe		
<input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
<input type="checkbox"/> Supported by		
<input type="checkbox"/> Vascular studies	<input checked="" type="checkbox"/> Claudication	<input type="checkbox"/> Extremity Ulcers
<input type="checkbox"/> Diminished or absent pulses	<input checked="" type="checkbox"/> Amputation	<input type="checkbox"/> Other
<input type="checkbox"/> History Diabetes		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Describe		
<input checked="" type="checkbox"/> Ulceration	<input type="checkbox"/> Gangrene	
Other		
<input type="checkbox"/> Describe		
<input type="checkbox"/> Active	<input checked="" type="checkbox"/> History of	<input type="checkbox"/> Rule out
<input type="checkbox"/> Supported by		
<input checked="" type="checkbox"/> History	<input type="checkbox"/> Symptoms	<input type="checkbox"/> Physical Findings
<input type="checkbox"/> Medications	<input type="checkbox"/> Test results	<input type="checkbox"/> Image studies
<input type="checkbox"/> Biopsy	<input type="checkbox"/> DME	<input type="checkbox"/> Other
<input type="checkbox"/> Other		

comments

CABG

History of Chest Pain

<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Pain described as	
<input type="checkbox"/> Achy	<input type="checkbox"/> Sharp
<input checked="" type="checkbox"/> Crushing	<input type="checkbox"/> Tight
<input type="checkbox"/> Does pain go into left arm	
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Is pain reproduced or worsened when touching chest or costochondral junctions	
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Is pain brought on by	

☒ **Exertion**
☐ Eating
 ☐ Stress / Anxiety
 ☐ Other

↳ Is pain relieved by oral medication

☐ Yes
 ☒ **No**

History of Intermittent Claudication

☒ **Yes**
☐ No

↳ Describe

☐ Complete heart block
 ☐ Sick sinus syndrome
 ☐ Bradycardia
 ☐ Other

comments

UNKNOWN

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 then one pillow?

☐ Yes
 ☒ **No**

have you ever have fluid in your lungs?

☐ Yes
 ☒ **No**

comments

NOT CURRENTLY

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

Peripheral Neuropathy

↳ Describe

☒ **Active** ☐ History Of ☐ Rule out

↳ Supported by

☒ **Physical findings** ☐ EMG / Nerve Conduction studies ☐ Biopsy

☐ Other

↳ Secondary to Diabetes

☒ **Yes** ☐ No

TIA

↳ Describe

☐ Active ☒ **History of** ☐ Rule out

↳ Supported by

☒ **History** ☐ Physical exam ☐ Image studies

☐ 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

☐ 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 ☐ No

☒ Patient oriented to time

- ☒ **Yes**
☐ **No**
- ☒ **Recall**
☐ **Poor**
- ☒ **Good**
☐ **Poor**
- ☒ **Patient describes recent news event**
☐ **Partially**
☐ **No**
- ☒ **Yes**
☐ **No**

Affect

- ☒ **Normal**
☐ **Abnormal**

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

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

PHQ 2 Score

- ☒ **< 3**
☐ **3 or more**

Speech

- ☒ **Normal**
☐ **Slurred**
☐ **Aphasic**
- ☐ **Apraxia**

Finger to Nose

- ☒ **Normal**
☐ **Abnormal**

Heel (Shin) to Toe

- ☐ **Normal**
☒ **Abnormal**
- ☒ **If abnormal**
☐ **Left**
☐ **Right**
☒ **Both**

comments

I.leg bka

Thumb to Finger Tips

- ☒ **Normal**
☐ **Abnormal**

Sitting to Standing

- ☐ **Normal**
☒ **Needs Assistance**
☐ **Unable**

Facial / Extremity Movement

- ☐ **Motor Tic**
☐ **Vocal Tic**
☐ **Benign (Essential Tremor)**
- ☐ **Intention Tremor**
☐ **Non-Intention (Pill rolling) Tremor**
☐ **Rigidity**
- ☐ **Spasticity**
☐ **Chorea Movement**
☐ **Cog wheeling**
- ☒ **Normal**

Gait

- ☐ **Normal**
☐ **Limp**
☐ **Wide based**
- ☐ **Abductor lurch**
☐ **Paretic**
☐ **Shuffling**

☐ Ataxic

☒ Other (Findings may also apply to Musculoskeletal diagnoses)

comments

L.LEG BKA, PVD, Prosthesis

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

Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ History

☐ Symptoms

☒ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Other

comments

L.Leg BKA

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

L.Leg

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

☐ Yes ☒ No

Endocrine Problems

☒ Yes ☐ 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

☒ Active ☐ History of ☐ Rule out

↳ Supported by

☒ Symptoms ☐ Physical findings ☐ Lab tests
☐ Medications ☐ Other

↳ Type

☐ Type 1 ☒ Type 2 ☐ Gestational

↳ Most recent Hb A1C, value

comments

UNKNOWN

↳ And Date

comments

UNKNOWN

↳ Met with a nurse or dietician for diabetic education

☒ Yes ☐ No

↳ Met with a diabetic educator

☒ Yes ☐ No

↳ Treatment includes

☐ Diet ☐ Oral hypoglycemic agent ☒ Insulin
☐ Exercise ☐ Weight loss

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

comments

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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
(mmHG)	(mmHG)	(bpm)				0

BMI

Patients Height		Patients Weight	Calculate BMI
6 (Feet)	0 (Inch)	212 (lbs)	28.7

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

Exam Review

Constitutional

General appearance:	Normal	Abnormal
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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 turbinates:	Normal	Abnormal
Inspection of lips, teeth and gums:	Normal	Abnormal
Examination of oropharynx:	Normal	Abnormal

Neck

Examination of neck:	Normal	Abnormal
Examination of thyroid:	Normal	Abnormal

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
Percussion of chest:	Normal	Abnormal
Palpation of chest:	Normal	Abnormal
Auscultation of lungs:	Normal	Abnormal

Cardiovascular

Palpation of heart:	Normal	Abnormal
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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
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Comment: L.BKA

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

Comment: L.BKA

Assessment of muscle strength/tone:	Normal	Abnormal
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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			No				ASSESSMENT COMPLETED VIRTUALLY
HBA1C	Yes	Select			No				
MICROALBUMIN	Yes	Select			No				
FOBT	Yes	Select			No				
DEXA	N/A	Select			Select				
PAD	Yes	Select			No				
LDL	No	Select			Select				

Mini-Cog

39. Mini- Cog (see attached sheet)

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.¹⁻³ For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test.

Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version : 1

Person's Answers: BANANA,SUNRISE,CHAIR

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

Home Safety & Personal Goals

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

- ☒ None
 ☐ Once
 ☐ Twice
 ☐ Three times
 ☐ More than three times

41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?	Yes	No
b. Do you have electrical cords running across floors, in doorways or under a rugs?	Yes	No
c. Do you have no slip mats on the shower floor or bath tub?	Yes	No
d. Do have adequate lighting in hallways and on the stairs?	Yes	No
e. Do you have handrails on staircases?	Yes	No
f. Is your hot water heater set for a maximum of 120 degrees?	Yes	No
g. Do you have smoke detectors on each level of the house and in all sleeping a rooms?	Yes	No
h. Do you have carbon Monoxide detectors on each level of the house?	Yes	No
i. Have used established an escape route in the event of fire?	Yes	No

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

"I WISH I NEVER STARTED SMOKING WHEN YOUNGER"

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 :

Assessment completed virtually, some items could not be obtained. ID verified via name and DOB

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 :	2021-07-15T14:13
Time exam finished	2021-07-15T15:13
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input checked="" type="checkbox"/>
Provider Signature	 <div>Digitally signed by Shante Tucker, NP 2021-07-18, 18:16</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?