

HRA Form

Health Plan :	Optima Health
Member Name :	DANNY K PICKETT
Evaluator Name :	Leslie Berryman, FNP
Assessment Type :	Health Risk Assessment
DOB :	1963-02-20
Evaluation Date :	2021-4-28 09:00 AM
Visit Type :	Virtual: Video & Audio Capability

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	DANNY K PICKETT
Gender	Male
Address	971 COON RIDGE RD
City	HILLSVILLE
State	VA
Zip	24343
Date of Birth	1963-02-20
Age(as of date)	58
Marital Status	Married
Member Identification Number	900040029*01
HICN	
Phone Number	276/733-6092
Cell Number	276/733-6092
Alternate Contact Number	
Email	
Emergency Contact	Kimberly Pickett
Phone Number	276-733-6092
Primary Care Physician	PERRY, ANGELICA DO
Phone Number	276/728-4311
PCP Address	702 PINE ST
PCP City	HILLSVILLE
PCP State	VA

PCP Zip	24343
PCP County	CARROLL
Office ID	10221870N
Office Name	

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

comments

completed 9th grade

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

 ↳ **Type**

☒ **Cigarettes**
☐ Cigars
 ☐ Chewing Tobacco

☐ Vaping
 ☐ Other

 ↳ **How Many**

☐ 1 - 3 a day
 ☐ 1/2 a pack
 ☒ **1 pack**

☐ More than 1 pack
 ☐ Other

comments

Taking Chantix for smoking cessation

14. Alcohol Use

☐ Current
 ☒ **Former**
☐ Never

comments

Patient has a history of alcoholism. Pt would drink both beer and liquor

How many drinks	How Often
9-12	Day

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
Pulmonologist		COPD

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

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

☒ Yes ☐ No

[Describe](#)

Bilateral hip replacement surgery

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
Mother	COPD	
Father	DM	

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	Not Applicable
Prostate Exam/PSA	Yes
If Diabetic Eye Exam	Don't Know
If Diabetic Foot Exam	Not Applicable
If Diabetic Hgb A1c screen	Not Applicable
Lipid Panel	Yes

28. Last colonoscopy if more than 2 years ago

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

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

☒ Yes ☐ No ☐ NA

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

☐ Yes ☐ No ☒ NA

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

☐ Yes ☐ No ☒ NA

32. Do you get Flu Vaccine each year?

☒ Yes ☐ No

33. Have you been vaccinated for Pneumonia?

☒ Yes ☐ No

↳ Pneumovax

☒ Yes ☐ No ☐ Unknown

↳ Prevenar

☐ Yes ☐ No ☒ Unknown

34. Have you been vaccinated for Herpes Zoster?

☐ Yes ☒ No

Allergies / Medications

35. Allergies

☐ Yes
☒ No

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
2021-04-28	ATORVASTATIN TAB	40MG	PO = By Mouth	HS		Taking	Not Taking
2021-04-28	FLUOXETINE CAP	40MG	PO = By Mouth	QD		Taking	Not Taking
2021-04-28	MAG-G	TAB 500MG	PO = By Mouth	BID		Taking	Not Taking
2021-04-28	AMLODIPINE TAB	5MG	PO = By Mouth	QD		Taking	Not Taking
2021-04-28	SPIRIVA	SPR 2.5MCG	Select	BID		Taking	Not Taking
2021-04-28	LACTULOSE SOL	10GM/15	PO = By Mouth	BID		Taking	Not Taking
2021-04-28	MIRTAZAPINE TAB	45MG	PO = By Mouth	HS		Taking	Not Taking
2021-04-28	SYMBICORT AER	160-4.5	Select	BID		Taking	Not Taking
2021-04-28	CHANTIX	PAK 0.5& 1MG	PO = By Mouth	BID		Taking	Not Taking
2021-04-28	CARVEDILOL TAB	3.125MG	PO = By Mouth	BID		Taking	Not Taking
2021-04-28	Albuterol HFA	90 MCG	Select	PRN		Taking	Not Taking
2021-04-28	Folic Acid	1mg	PO = By Mouth	QD		Taking	Not Taking
	MIRTAZAPINE	TAB 45MG	Select	Select		Taking	Not Taking
	SPIRIVA	SPR 2.5MCG	Select	Select		Taking	Not Taking
	MAGNESIUM	TAB 27MG	Select	Select		Taking	Not Taking
	ATORVASTATIN	TAB 40MG	Select	Select		Taking	Not Taking
	CARVEDILOL	TAB 3.125MG	Select	Select		Taking	Not Taking
	CONSTULOSE	SOL 10GM/15	Select	Select		Taking	Not Taking
	MAG-G	TAB 500MG	Select	Select		Taking	Not Taking
	AMLODIPINE	TAB 5MG	Select	Select		Taking	Not Taking
	SYMBICORT	AER 160-4.5	Select	Select		Taking	Not Taking
	LACTULOSE	SOL 10GM/15	Select	Select		Taking	Not Taking
	FLUOXETINE	CAP 40MG	Select	Select		Taking	Not Taking
	CHANTIX	PAK 0.5& 1MG	Select	Select		Taking	Not Taking
	CHLORTHAL	TAB 25MG	Select	Select		Taking	Not Taking

	ID						
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36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
04-21-2021	ASA	326 MG	PO = By Mouth	QD
04-28-2021	MVI		PO = By Mouth	QD

37. Chronic Use of

☐ None

☒ ASA ☐ Steroids ☐ Insulin
☐ Anticoagulants ☒ Statins ☐ Biphosphonate

38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?	Yes	No
2. Do you sometimes not pay enough attention to your medication?	Yes	No
3. Do you know the longterm benefit of taking your medicine as told to you by the doctor or pharmacist?	Yes	No
4. When you feel better do you sometimes stop taking your medicine?	Yes	No
5. Sometimes if you feel worse when you take your medicine do you stop taking it?	Yes	No
6. Do you sometimes forget to refill your prescription on time?	Yes	No

Review of Systems and Diagnoses

Eye Problems (Glaucoma, Cataracts, Macular Degeneration, Blindness, Retinal Detachment, Other)

☒ Yes ☐ No

Diagnoses

☐ Cataracts ☐ Difficulty with vision
☐ Glaucoma ☐ Hyperopia
☐ Macular Degeneration ☒ Myopia
☐ Retinal Disease ☐ Others

Myopia

Describe

☒ Active ☐ History of ☐ Rule out

Supported by

☐ Symptoms ☒ Glasses/ lenses ☐ Other

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

Do you have eye pain?

☐ Yes ☒ No

Do you have problems with tearing?

☐ Yes ☒ No

Do you have a problem with dry eye?

☐ Yes ☒ No

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

☒ Yes ☐ No

↳ Diagnoses

☒ Difficulty with Hearing

☐ Tinnitus

☐ Other

☐ Legally Deaf

☐ Vertigo

Difficulty with Hearing

↳ Describe

☒ Active

☐ History of

☐ Rule out

Do you have trouble hearing when people talk to you?

☒ Yes ☐ No

Do you wear a hearing aid?

☐ Yes ☒ No

Do you read lips?

☐ Yes ☒ No

Do you have ear pain or drainage?

☐ Yes ☒ No

Do you ever get dizzy?

☐ Yes ☒ No

Nose Problems (Nose Bleeds, Sinus infections, Other)

☐ Yes ☒ No

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

☐ Yes ☒ No

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes ☒ No

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

☒ Yes ☐ No

↳ Diagnoses

☐ Acute Pulmonary Embolism

☐ Asthma

☐ Chronic Respiratory Failure

☒ COPD

☐ Hypoventilation secondary to Obesity

☐ Acute Upper Respiratory Infection

☐ Chronic Pulmonary Embolism

☐ Chronic Sputum Production

☐ Cystic Fibrosis

☐ Hypoxemia

- ☐ Pneumonia

☐ Respirator Dependence/
Tracheostomy Status

☐ Sarcoidosis

☐ Other
- ☐ Pulmonary Fibrosis

☐ Respiratory Arrest

☐ Sleep Apnea
- ☐ COPD

Describe

☒ Active

History of

Rule out

Supported by

☐ Use of accessory
muscles

☒ Wheezing

Barrel Chest

Clubbing

XR results

Decreased or
prolonged breath
sounds

☒ Brinchodilator
medication

☒ Dyspnea on exertion

☒ O2 use

☐ Respirator

☐ Other

comments

Oxygen 2 LPM HS

- Has patient been told they have Chronic Bronchitis

☐ Yes

☒ No
- Has patient been told they have Emphysema

☐ Yes

☒ No
- Is patient on Bronchodilator

☒ Yes

☐ No

comments

Albuterol HFA

- Route is

☒ Inhaled

☐ Nebulizer

☐ Oral
- Is patient on Steroids

☒ Yes

☐ No

comments

Symbicort, Spiriva

- Route is

☒ Inhaled

☐ Nebulizer

☐ Oral
- Does patient have current exacerbation

☐ Yes

☒ No

Use of Oxygen

- ☒ Yes

☐ No
- Describe

☐ PRN

☐ Continuous

☐ Day

☒ Night
- Litres / Min

2

Shortness of breath

- ☒ Yes

☐ No

Wheezing

- ☒ Yes

☐ No

Chronic Cough

- ☒ Yes

☐ No

Patient requires durable medical equipment

☒ Yes

☐ No

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

☒ Yes

☐ No

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

comments

Atorvastatin

Hypertension

Describe

☒ **Active**
☐ History of

☐ Rule out

Supported by

☐ Physical Exam

☒ **Medications**
☐ Symptoms

☐ Other

comments

Amlodipine, Coreg, ASA

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

- ↳ Describe
 - ☒ Active
- ↳ Supported by
 - ☐ Symptoms
 - ☐ History of
 - ☐ Rule out
 - ☐ PHQ 2 / 9
 - ☒ Use of antidepressant medication
 - ☐ Other
- ↳ Major
 - ☒ Yes
 - ☐ NO
- ↳ Supported by
 - ☐ PHQ 9
 - ☐ Hospitalization
 - ☒ Chronic use of antidepressant medication beyond 6 months
 - ☐ Use of ECT

comments

Prozac, Remeron

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

☒ 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**
☐ 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**

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

☐ Yes

☒ **No**

Endocrine Problems

☐ Yes

☒ **No**

Have you lost weight in the past 6 months?

☒ **None**

☐ 15lbs

☐ 5lbs

☐ More than 15lbs

☐ 10lbs

☐ 10% of your weight (calculated by assessor)

Hematology / Immunology / Infection Disease Problems (Anemia, easy bruising or abnormal bleeding Thrombocytopenia , Other)

☒ Yes
 ☐ No

Diagnoses

- ☐ AIDS
 ☐ C. Difficile
 ☐ HIV
 ☐ Hospital Acquired MRSA Infection
 ☐ Leukemia
 ☐ Multiple Myeloma
 ☐ Sickle Cell Disease
 ☐ Thalassemia
 ☐ Tuberculosis
- ☐ Anemia
 ☐ Community Acquired MRSA Infection
 ☐ Herpes Zoster
 ☐ Immune Deficiency
 ☐ Lymphoma
 ☐ Sepsis
 ☐ Sickle Cell Trait
 ☐ Thrombocytopenia
 ☐ Vitamin D Deficiency

☒ Other

Other

Describe

☒ Active
 ☐ History of
 ☐ Rule out

Supported by

☒ History
 ☒ Symptoms
 ☐ Physical Findings

☒ Medications
 ☐ Test results
 ☐ Image studies

☐ Biopsy
 ☐ DME
 ☐ Other

Other

comments

Elevated Ammonia levels due to history of Alcoholism.
 Takes Lactulose, Folic Acid and Mag Ox daily

Easy bruising or abnormal bleeding

☐ Yes
 ☒ No

Long term anticoagulation use

☐ Yes
 ☒ No

Cancer

Diagnosis of Cancer	Yes	No
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Pain

Does the patient experience pain?

☐ Yes
 ☒ No

Vital Signs

Vital Signs

comments

Virtual visit

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

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	5 (Inch)	180 (lbs)	30.0

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

Exam Review

Constitutional

General appearance:	Normal	Abnormal
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Head and Face

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

Comment: Virtual visit

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

Comment: difficulty hearing

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
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Comment: no swelling observed

Examination of thyroid:	Normal	Abnormal
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Comment: no goiter observed

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
Comment: No s/s of SOB or Respiratory distress		
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
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Comment: Virtual visit

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

Mini-Cog

39. Mini- Cog (see attached sheet)

Step 1: Three Word Registration

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

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

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

Step 2: Clock Drawing

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

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

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

Step 3: Three Word Recall

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

Word List Version : 3

Person's Answers: **table, baby, chair**

Word Recall :	0 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 :	2 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?

nothing

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

nothing

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, address, and wife. Pt is a pleasant 58 year old male that lives with his wife. Pt is independent with all ADLs. Patient reports he had both hips replaced at the same time over a year ago.

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 :	2021-04-28T10:00
Time exam finished	2021-04-28T10:50
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input checked="" type="checkbox"/>
Provider Signature	<div> <div> Leslie Berryman, NP-C </div> <div>  </div> <div> Digitally signed by Leslie Berryman, FNP 2021-05-04, 09:30 </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?