

HRA Form

Health Plan :	Optima Health
Member Name :	CHARLIE D WATKINS
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1937-02-19
Evaluation Date :	2021-7-21 04:30 PM
Visit Type :	

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	CHARLIE D WATKINS
Gender	Male
Address	202 ENGLEWOOD LN
City	DANVILLE
State	VA
Zip	24541-9998
Date of Birth	1937-02-19
Age(as of date)	84
Marital Status	Married
Member Identification Number	900041836*01
HICN	
Phone Number	434/688-5289
Cell Number	434/688-5289, 434/688-5289
Alternate Contact Number	434/688-5289, 434/688-5289,
Email	
Emergency Contact	Amanda Robertson, daughter
Phone Number	434688-5289
Primary Care Physician	VASIREDDY, VENUGOPAL K MD
Phone Number	434/799-2055
PCP Address	1955 MEMORIAL DRIVE
PCP City	DANVILLE
PCP State	VA

PCP Zip	24541
PCP County	
Office ID	140590
Office Name	

1. Race

- | | | |
|---|---|--|
| <input type="checkbox"/> Caucasian | <input checked="" type="checkbox"/> African American | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Latino | <input type="checkbox"/> Native American | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Other | |

Patient's Ethnicity

- | | | |
|--|---|--|
| <input type="checkbox"/> Hispanic | <input checked="" type="checkbox"/> Non-Hispanic | <input type="checkbox"/> Other Ethnicity |
| <input type="checkbox"/> Prefer not to say | | |

2. Preferred language

- | | |
|--|--------------------------------|
| <input checked="" type="checkbox"/> English | <input type="checkbox"/> 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?

- | | | |
|---|--|--|
| <input type="checkbox"/> Less than 3rd grade | <input type="checkbox"/> Completed 3rd grade | <input type="checkbox"/> Completed 8th grade |
| <input checked="" type="checkbox"/> Completed 12th grade | <input type="checkbox"/> 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
↳ **Type**
☒ **Cigarettes** ☐ Cigars ☐ Chewing Tobacco
☐ Vaping ☐ Other
↳ **How Many**
☐ 1 - 3 a day ☐ 1/2 a pack ☒ **1 pack**
☐ More than 1 pack ☐ Other

14. Alcohol Use

- ☐ Current ☐ Former ☒ **Never**

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

☐ Yes ☒ No

16. Do you have a Healthcare Proxy?

☐ Yes ☒ No ☐ Don't Know

17. Do you have a Durable Power of Attorney?

☒ Yes ☐ No ☐ Don't Know

↳ Name

Amanda Robertson

↳ Relationship

daughter

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

Comment: has a personal care worker who comes in daily to assist with ADLs

↳ How far can you walk

☐ Household only ☒ Less than one block ☐ One block
☐ Two or more blocks ☐ Non-ambulatory

H. Going up or down stairs	No	Need Some Help	Need Total Help
----------------------------	----	----------------	-----------------

↳ How many stairs can you climb

☐ None ☒ Three to five ☐ Six to ten

☐ More than ten

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
Podiatrist	Dr Patel	callous trimming
Nephrologist	Dr Cassidy	CKD3
Cardiologist	Dr. Zagol	Elaquis monitoring/DVT

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

fell after tripping on O2 tubing, landed on floor left side

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

If one or more, describe

NH for rehab after fall

E. Had Surgery	None	1	2	3	4	5 or more
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23. Have you ever been hospitalized prior to the last 12 months?

- ☐ Yes
- ☒ No

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

Physical Therapist	Yes	No
Comment: PT 2 x week		
Occupational Therapist	Yes	No

Comment: 2 x week

Dietician	Yes	No
Social Worker	Yes	No
Pharmacist	Yes	No
Speech Therapist	Yes	No
Chiropractor	Yes	No
Personal Care Worker (HHA, CNA, PCA)	Yes	No

Comment: she is there 7 days per week/ 4 hrs per day

Meals on Wheels	Yes	No
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25. In the past two years have you received any of the treatments below?

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

Comment: insulin injections daily

Tube Feedings	Yes	No	Unknown
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Family History

26. Family History

☒ Yes

☐ No

Family Member	Medical Condition	Cause of Death
Mother	DMII	natural causes age 90's

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	No
If Diabetic Eye Exam	Yes
If Diabetic Foot Exam	Yes
If Diabetic Hgb A1c screen	Yes

Lipid Panel	Yes
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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

aged out

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

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
schizophrenia	HALOPERIDOL	TAB 5MG	PO = By Mouth	HS	VASISREDDY	Taking	Not Taking
COPD	IPRATROPIUM / SOL ALBUTEROL	SOL ALBUTEROL	PO = By Mouth	QD	VASIREDDY	Taking	Not Taking
DMII	LEVEMIR	INJ FLEXTUOC	SQ = Subcutaneous	QD	VASIREDDY	Taking	Not Taking

			s				
DMII	INSULIN LISP	INJ 100/ML	SQ = Subcutaneous	QD	VASIREDDY	Taking	Not Taking
GERD	OMEPRAZOLE	CAP 20MG	PO = By Mouth	QAM	VASIREDDY	Taking	Not Taking
neuropathy BLE	GABAPENTIN	CAP 300MG	PO = By Mouth	TID	VASIREDDY	Taking	Not Taking
HTN, DMII	LOSARTAN POT	TAB 100MG	PO = By Mouth	QAM	VASIREDDY	Taking	Not Taking
HTN	AMLODIPINE	TAB 5MG	PO = By Mouth	QAM	VASIREDDY	Taking	Not Taking
BPH, nocturia	TAMSULOSIN	CAP 0.4MG	PO = By Mouth	HS	VASIREDDY	Taking	Not Taking
constipation	STOOL SOFTENER	100mg	PO = By Mouth	HS	VASIREDDY	Taking	Not Taking
COPD	TRELEGY ELLIPTA	100 mcg	PO = By Mouth	QAM	VASIREDDY	Taking	Not Taking
DVT left leg	ELIQUIS	5mg	PO = By Mouth	BID	VASIREDDY	Taking	Not Taking
HLD	lipitor	20mg	PO = By Mouth	HS	VASIREDDY	Taking	Not Taking

36. Over the Counter Medications / Supplements

☐ Yes

☒ No

37. Chronic Use of

☐ None

☐ ASA

☒ Anticoagulants

☐ Steroids

☒ Statins

☒ Insulin

☐ Biphosphonate

38. Medication Compliance and Knowledge of Use and Disease

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

Review of Systems and Diagnoses

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

☐ Yes

☒ No

Do you wear glasses or contacts?

☒ Yes☐ No

Do you have trouble seeing even with glasses?

☐ Yes☒ No

Do you have problems seeing at night?

☐ Yes☒ No

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

☐ Yes☒ No

Nose Problems (Nose Bleeds, Sinus infections, Other)

☐ Yes☒ No

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

☐ Yes☒ No

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes☒ No

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

☒ Yes☐ No

Diagnoses

- ☐ Acute Pulmonary Embolism☐ Acute Upper Respiratory Infection☐ Asthma☐ Chronic Pulmonary Embolism☐ Chronic Respiratory Failure☐ Chronic Sputum Production☒ COPD☐ Cystic Fibrosis☐ Hypoventilation secondary to Obesity☐ Hypoxemia☐ Pneumonia☐ Pulmonary Fibrosis☐ Respirator Dependence/Tracheostomy Status☐ Respiratory Arrest☐ Sarcoidosis☐ Sleep Apnea☐ Other

comments

DAUGHTER REPORTS MEMBER DOES NOT HAVE CHRONIC RESPIRATORY FAILURE

COPD

Describe

☒ Active☐ History of☐ Rule out

Supported by

☐ Use of accessory muscles☐ Barrel Chest☐ XR results☐ Wheezing☐ Clubbing☐ Decreased or prolonged breath sounds

☒ Dyspnea on exertion☒ O2 use☒ Brinchodilator medication

☐ Respirator☐ Other

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

↳ Route is

☒ Inhaled ☐ Nebulizer ☐ Oral

↳ Is patient on Steroids

☐ Yes ☒ No

↳ Does patient have current exacerbation

☐ Yes ☒ No

Use of Oxygen

☒ Yes ☐ No

↳ Describe

☐ PRN ☒ Continuous ☐ Day

☐ Night

↳ Litres / Min

2L

Shortness of breath

☒ Yes ☐ No

Wheezing

☐ Yes ☒ No

Chronic Cough

☒ Yes ☐ No

Patient requires durable medical equipment

☒ Yes ☐ No

comments

O2 tanks

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

☒ Yes ☐ No

↳ Diagnoses

☐ Abnormal Cardiac Rhythm
☐ Angina
☐ Cardio – Respiratory Failure / Shock

☐ Aneurysm
☐ Atrial Fibrillation
☐ Cardiomyopathy

☐ Congestive Heart Failure

☒ Hyperlipidemia

☐ Ischemic Heart Disease (CAD)

☒ Peripheral Vascular Disease

☐ Valvular Disease

☒ Deep Vein Thrombosis

☒ Hypertension

☐ Myocardial Infarction

☐ Pulmonary Hypertension

☒ Other

Deep Vein Thrombosis

↳ Describe

☐ Acute ☒ Chronic

↳ Describe

☒ Active ☐ History of ☐ Rule out

↳ Supported by

☐ Physical findings ☒ Use of ☐ Vascular studies

☐ Vena Cava filter

☒ anticoagulation

☒ Edema

☐ Other

Use of anticoagulation

Describe

☐ Prophylactic

☒ Therapeutic

Persistent for three months or more

☒ Yes

☐ No

Hyperlipidemia

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Lab results

☒ Medication

☐ Other

Is patient on Statin

☒ Yes

☐ No

Hypertension

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Physical Exam

☒ Medications

☐ Symptoms

☐ Other

Adequately controlled

☒ Yes

☐ No

☐ UnKnown

Peripheral Vascular Disease

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Vascular studies

☐ Claudication

☐ Extremity Ulcers

☐ Diminished or absent pulses

☐ Amputation

☐ Other

comments

had ABI testing at hospital- Sova Hospital, Danville VA

☒ History Diabetes

☒ Yes

☐ No

Describe

☐ Ulceration

☐ Gangrene

comments

only neuropathy BLE

☐ Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ History

☐ Symptoms

☒ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Other

comments


chronic edema bil feet/ankles

History of Chest Pain

☐ Yes

☒ No

History of Intermittent Claudication



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☐ 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 then 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

☐ Bowel Obstruction

☐ Celiac Disease

☐ Colon Polyps

☐ Gall Bladder Disease

☒ GERD

☐ Inflammatory Bowel Disease

☐ Ulcer Disease

☐ Cachexia

☐ Cirrhosis

☐ Diverticulitis

☐ Gastroparesis

☐ Hepatitis

☐ Pancreatitis

☒ Other

GERD

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☒ Heartburn /
Dyspepsia

☐ Regurgitation

☒ Medications

☐ Other

Other

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☐ History

☐ Symptoms

☐ Physical Findings

☒ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

↳ Other

comments

constipation, on stool softener

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

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

comments

on stool softener

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

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

☐ Alcohol Dependence

☐ Amyotrophic Lateral Sclerosis

- ☐ Bipolar Disorder

☐ Cerebral Palsy

☐ Dementia

☐ Drug Dependence

☐ Generalized Anxiety Disorder

☐ Hemiparesis

☐ Insomnia

☐ Migraine Headaches

☐ Muscular Dystrophy

☐ Parkinson's disease

☐ Restless leg syndrome

☐ Seizure Disorder

☐ Stroke

☐ TIA

☐ Other
- ☐ Cerebral Hemorrhage

☐ Delusional Disease

☐ Depression

☐ Fibromyalgia

☐ Guillain-Barre Disease

☐ Huntington's Chorea

☐ Intellectual and or Developmental Disability

☐ Multiple Sclerosis

☐ Myasthenia Gravis

☒ Peripheral Neuropathy

☒ Schizophrenia

☐ Spinal Cord Injury

☐ Subdural Hematoma

☐ Traumatic Brain Injury

Peripheral Neuropathy

Describe

☒ Active

Supported by

☒ Physical findings

☐ Other

☐ History Of

☐ Rule out

☐ EMG / Nerve Conduction studies

☐ Biopsy

comments

numbness and tingling in BLE

Secondary to Diabetes

☒ Yes

☐ No

Schizophrenia

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Affect

☐ Specific symptoms for 6 months or more

☒ Medication

☒ Hospitalization

☐ Psychosis

☐ Other

comments

hospitalized more than 20 yrs ago

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

☐ Partially

☐ No

☒ Patient describes recent news event

☐ No

☒ Yes

☐ Partially

☐ No

Affect

☒ Normal

☐ Abnormal

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

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

PHQ 2 Score

☒ < 3

☐ 3 or more

Speech

☒ Normal

☐ Slurred

☐ Aphasic

☐ Apraxia

Finger to Nose

☒ Normal

☐ Abnormal

Heel (Shin) to Toe

☒ Normal

☐ Abnormal

Thumb to Finger Tips

☒ Normal

☐ Abnormal

Sitting to Standing

☒ Normal

☐ Needs Assistance

☐ Unable

Facial / Extremity Movement

☐ 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)

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

☒ Yes

☐ No

Diagnoses

- ☐ Acute Renal Failure
- ☒ **Chronic Kidney Disease**
- ☐ Erectile Dysfunction
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☒ **BPH**
- ☐ ESRD
- ☐ Frequent UTI
- ☐ Nephritis or Nephrosis
- ☐ Other

BPH

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☐ Physical exam

☒ **Symptoms**

☐ Lab test

☐ Biopsy

☒ **Medication**

☐ Hospitalization

☐ Other

comments

nocturia 6 times per nite average

Chronic Kidney Disease

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☒ **Lab tests**

☐ Calculated GFR X 3

☐ Other

What stage

☐ 1 [GFR > 89]

☐ 2 [GFR 60-89]

☒ **3 [GFR 30-59]**

☐ 4 [GFR15-29]

☐ 5 [GFR <15]

Secondary to Diabetes

☒ **Yes**

☐ No

Secondary to Hypertension

☒ **Yes**

☐ No

History of frequency

☒ **Yes**

☐ No

☐ 3x / day

☐ 4x / day

☐ 5x / day

☒ **>5x / day**

History of Nocturia

☒ **Yes**

☐ No

☐ 1x / night

☐ 2x / night

☐ 3x / night

☒ **>=4x / night**

History of Hesitancy

☐ Yes

☒ **No**

Do you have trouble urinating?

☐ Yes

☒ **No**

Do you ever have blood in your urine?

☐ Yes

☒ **No**

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

- ☐ Yes ☒ No
- Do you have trouble holding your urine?
- ☐ Yes ☒ No
- Do you trouble getting to the bathroom on time?
- ☐ Yes ☒ No
- Do you ever have pain or burning during urination?
- ☐ Yes ☒ No
- Do you ever wear pads or diapers?
- ☐ Yes ☒ No
- Do you have a vaginal discharge?
- ☐ Yes ☒ No
- Do you have vaginal bleeding?
- ☐ Yes ☒ No

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

- ☐ Yes ☒ No

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

- ☒ Yes ☐ No

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Dermatitis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Skin ulcer | <input type="checkbox"/> Urticarial Disease |
| <input type="checkbox"/> Wound | <input checked="" type="checkbox"/> Other |

Other

Describe

- ☒ Active ☐ History of ☐ Rule out

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 |

Other

comments

has Acquired keratosis [keratoderma] palmaris et plantaris - callous on bilat feet, Podiatrist shaves them down whenever they become bothersome

Do you have ulcers or wounds that require dressings?

- ☐ Yes ☐ No

Do you have a chronic skin condition?

- ☒ Yes ☐ No

comments

Acquired keratosis [keratoderma] palmaris et plantaris- callouses on feet

Does your skin problem require the use of chronic medication, cream or ointment?

- ☐ Yes ☐ No

Do you get pains in your legs when you walk that make you stop to get relief?

- ☐ Yes ☐ No

Do you have skin breakdown or ulcers around your ankles?

- ☐ Yes ☐ No

Endocrine Problems

☒ Yes

☐ No

Diagnoses

☒ **Chronic Kidney Disease secondary to Diabetes**
☐ Cushing's Disease

☐ Diabetic Retinopathy

☒ **Hypertension and Diabetes**
☐ Hypothyroidism

☐ Peripheral Neuropathy secondary to Diabetes

☐ Hyperparathyroidism

☐ Coronary Artery Disease and Diabetes

☒ **Diabetes**
☐ Secondary Hyperparathyroidism

☐ Hyperthyroidism

☐ Kidney Stone

☐ Peripheral Vascular Disease secondary to Diabetes

☐ Other

Chronic Kidney Disease secondary to Diabetes

Describe

☒ **Active**
☐ History of

☐ Rule out

Supported by

☐ Decreased GFR

☐ Albuminuria

☒ **Elevated BUN/ Creatinine**
☐ Dialysis

☐ Other

Patient on ACE or ARB

☒ **Yes**
☐ No

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

7.1

And Date

comments

July2021 per daughter

Met with a nurse or dietician for diabetic education

☐ Yes

☒ **No**

Met with a diabetic educator

☐ Yes

☒ **No**

Hypertension and Diabetes

Describe

☒ **Active**
☐ History of

☐ Rule out

Supported by

☒ **History**
☐ Symptoms

☐ Physical Findings

☒ **Medications**
☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Is patient on Ace or ARB

☒ **Yes**
☐ No

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

☐ Yes

☒ No

Do you often feel thirsty?

☒ Yes

☐ No

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

☒ Yes

☐ No

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

☒ Yes

☐ No

Do you get ulcers on your legs or feet?

☐ Yes

☒ No

Do you feel sluggish?

☐ Yes

☒ No

Do you sweat a lot or constantly feel hot?

☐ Yes

☒ No

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

☒ Yes

☐ No

Have you ever had dialysis?

☐ Yes

☒ No

Is your skin itchy?

☐ Yes

☒ No

Do you test your blood sugar?

☐ Yes

☒ No

Have you lost weight in the past 6 months?

☐ None

☐ 5lbs

☒ 10lbs

☐ 15lbs

☐ More than 15lbs

☐ 10% of your weight (calculated by assessor)

comments

while in NH/rehab, gaining some of it back since being back home

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

☐ Yes

☒ No

Cancer

Diagnosis of Cancer	Yes	No
---------------------	-----	----

Pain

Does the patient experience pain?

☒ Yes

☐ No

comments

in BLE neuropathy and PAD pain in legs at intervals when walking

Is the Pain Acute?

☐ Yes

☒ No

Is the Pain Chronic?

☒ Yes

☐ No

 Describe

☒ **Active**
☐ History of

☐ Rule out

Where

BLE

Do you take Methadone

☐ Yes

☒ **No**

What drug/s do you take for it

gabapentin

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

6/10

Is the Patient Undergoing Pain Management Planning?

☐ Yes

☒ **No**

Was the patient advised regarding the potential for dependence?

☐ Yes

☒ **No**

Is there any evidence of Maladaptive Behavior?

Tolerance?

☐ Yes

☒ **No**

Withdrawal?

☐ Yes

☒ **No**

Increased usage over a longer period that intended?

☐ Yes

☒ **No**

Desire or unsuccessful effort to cut down on use?

☐ Yes

☒ **No**

Excess time spent in activities to obtain the substance?

☐ Yes

☒ **No**

Continued use despite Doctor advice or patient knowledge of habituation?

☐ Yes

☒ **No**

Physical or Psychological Problem related to the substance use?

☐ Yes

☒ **No**

Vital Signs

Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
(mmHG)	(mmHG)	(bpm)				6

BMI

Patients Height		Patients Weight	Calculate BMI
6 (Feet)	0 (Inch)	238 (lbs)	32.3

☒ **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

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

Comment: wears dentures upper and lower

Examination of oropharynx:	Normal	Abnormal
----------------------------	--------	----------

Neck

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

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
-----------------------------------	--------	----------

Comment: daughter feels like he labors to breath

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

Cardiovascular

Palpation of heart:	Normal	Abnormal
Auscultation of heart:	Normal	Abnormal

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

Lymphatic

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

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
----------------------------------	--------	----------

Comment:

ambulates well with walke for support post fall

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

Skin

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

Neurologic

Indicate specific cranial nerve tested

II-XII

Indicate cranial nerve deficits found

none

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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RFoot

LFoot

Bilateral

Comments: callouses medial metatarsals

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	Yes	Refused Kit			Select				
HBA1C	Yes	Refused Kit			Select				
MICROALBUMIN	Yes	Refused Kit	4444444444	4444444444	Select				
FOBT	No	Select			Select				
DEXA	N/A	Select			Select				
PAD	Yes	Refused Kit			Select				
LDL	No	Select			Select				

Mini-Cog

39. Mini- Cog (see attached sheet)

Step 1: Three Word Registration

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

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

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

Step 2: Clock Drawing

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

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

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

Step 3: Three Word Recall

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

Word List Version : 1

Person's Answers: banana chair sunrise

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

comments

fell at home, tripped on O2 tubing, fell hard on floor, ambulance called and kept overnight at hospital then to NH for rehab

- Do you worry about falling or feeling unsteady when standing or walking

☐ Yes

☒ No
- Worries about falling or feeling unsteady when standing or walking?

☐ Yes

☒ No
- Did you have a fracture in past 6 months?

☒ Yes

☐ No

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?
would be good to breathe better

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 with member. his daughter was present for the interview and was able to fill in many gaps as member is on constant O2 and it is sometimes hard to talk and breath with COPD

Daughter showed and identified her father with his Optima ID card. She reports he fell over a month ago at home on lt side and fractures a few ribs. He is doing well post rehab. The member denies metatarsalgia and or rt toe pain listed in preexisting conditions. He has PAD and a DVT. He has chronic edema in Bil feet and ankles and wears no support hose. Daughter says he is not a a special diet and eats what he wants.


Member denies tinea ungium as in preexisting dx.

PE portions and areas left blank in PE; auscultation, percussion, palpation, rhomberg, reflex testing, vital signs, exams of orifices could not be performed due to virtual visit

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 :	2021-07-21T16:27
Time exam finished	2021-07-21T17:29
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>Digitally signed by Lori Rutherford, AGNP 2021-07-28, 20:01</div></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?