

HRA Form

Health Plan :	Optima Health
Member Name :	MARY M FISCHBACH
Evaluator Name :	Brittney Walls, FNP
Assessment Type :	Health Risk Assessment
DOB :	1941-06-02
Evaluation Date :	2021-6-11 01:00 PM
Visit Type :	In Person

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	MARY M FISCHBACH
Gender	Female
Address	1021 GERMAN SCHOOL ROAD APT 123
City	RICHMOND
State	VA
Zip	23223-9998
Date of Birth	1941-06-02
Age(as of date)	80
Marital Status	Married
Member Identification Number	900042478*01
HICN	
Phone Number	804/651-7088
Cell Number	804/651-7088,
Alternate Contact Number	804/651-7088,
Email	
Emergency Contact	Thomas H. Fischbach Jr.
Phone Number	8049820162
Primary Care Physician	PHYSICIAN, MR PRIMARY CARE MD
Phone Number	8045600490
PCP Address	4417 CORPORATION LANE
PCP City	VIRGINIA BEACH
PCP State	VA

PCP Zip	23462
PCP County	
Office ID	799MR
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

### 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

comments

someday smoker

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

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
Comment: uses rollator walker			
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**

 Describe

rollator walker, electric wheelchair

21. Are you currently seeing any specialists?

☒ Yes

☐ No

Medical Specialty	Specialist	For
Cardiologist	Denise Deets	SSS, AAA, pacemaker/defibrillator
Other	Hepatologist (unknown)	elevated liver enzymes
Nephrologist	Dr. Condro	CKD

## 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

## 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
Select Family Member	unknown family history - both parents died when very young and her brothers and sisters are scattered throughout the US and she's lost contact	

## Preventive Care

### 27. In the past three years have you had?

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

comments

member has AAA

### 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	
	IPRATROPIUM/ M/	SOL ALBUTER	Select	Select		Taking	Not Taking
	ALBUTEROL	NEB 0.00083	Select	Select		Taking	Not Taking
	METOPROLOL SUC	TAB 25MG ER	Select	Select		Taking	Not Taking
	SPIRIVA	CAP HANDIHLR	Select	Select		Taking	Not Taking
	OXYCODONE	TAB 10MG	Select	Select		Taking	Not Taking
	ALPRAZOLAM	TAB 1MG	Select	Select		Taking	Not Taking
	LOSARTAN POT	TAB 25MG	Select	Select		Taking	Not Taking
	VENTOLIN HFA	AER	Select	Select		Taking	Not Taking
	MUPIROCAIN	OIN 0.02	Select	Select		Taking	Not Taking
	BUMETANIDE	TAB 1MG	Select	Select		Taking	Not Taking
	FLUTICASON E	SPR 50MCG	Select	Select		Taking	Not Taking
	TRAZODONE	TAB 50MG	Select	Select		Taking	Not Taking
	GLIMEPIRIDE	TAB 1MG	Select	Select		Taking	Not Taking
	METOPROLOL SUCCLINATE ER		Select	Select		Taking	Not Taking
	SPIRIVA HANDIHALER		Select	Select		Taking	Not Taking
	ALBUTEROL SULFATE		Select	Select		Taking	Not Taking
	IPRATROPIUM BROMIDE/ ALBUTEROL SULFATE		Select	Select		Taking	Not Taking
	OXYCODONE HYDROCHLORIDE		Select	Select		Taking	Not Taking
	FLUTICASON		Select	Select		Taking	Not Taking

	E PROPIONAT E						
	TRAZODONE HYDROCHLO RIDE		Select	Select		Taking	Not Taking
	LOSARTAN POTASSIUM		Select	Select		Taking	Not Taking
	ALBUTEROL SULFATE HFA		Select	Select		Taking	Not Taking
	MUPIROCIN		Select	Select		Taking	Not Taking

### 36. Over the Counter Medications / Supplements

☐ Yes ☐ No

### 37. Chronic Use of

☐ None

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

comments

aspirin

### 38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?	Yes	No
Comment:	sometimes	
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
Comment:	sometimes	
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



comments

cataracts, history of, symptoms, b/l cataract removal

### Cataracts

#### Describe

☐ Active

☒ History of

☐ Rule out

#### Supported by

☐ History

☒ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

#### Secondary to Diabetes

☐ Yes

☒ No

### Difficulty with vision

#### Describe

☒ Active

☐ History of

☐ Rule out

comments

active - wears reading glasses

#### Legally Blind

☐ Yes

☒ No

### Do you wear glasses or contacts?

☒ Yes

☐ No

comments

reading glasses

#### 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

### Nose Problems (Nose Bleeds, Sinus infections, Other)

☒ Yes

☐ No

#### Diagnoses

☐ Chronic Post Nasal Drip

☐ Nose Bleeds

☐ Sinus Infections

☐ Other

comments

allergic rhinitis, uses medications, verified by history, physical finding, medication

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

☐ Yes

☒ No

comments

no issues chewing food, has upper dentures

### 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

☒ **Pneumonia**

☒ **Respirator Dependence/Tracheostomy Status**

☐ Sarcoidosis

☐ Other

**Asthma**

Describe

☐ Active

☒ **History of**

☐ Rule out

comments

yes, history of, inhaled steroids, use of ventilator -- Portable ventilator Trilogy

Supported by

☐ Wheezing

☐ Use of Bronchodilator

☐ Other

☐ Chronic Cough

☐ Use of Inhaled or oral steroids

☐ Cyanosis

☐ Use of ventilator

Is patient on controller medications

☒ **Yes**

☐ No

Does patient use rescue medications

☒ **Yes**

☐ No

Does patient have current exacerbation

☐ Yes

☒ **No**

Chronic Respiratory Failure

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☒ **History of hospitalization with Respiratory Failure**

☐ Use of ventilator

☐ Chronic use of O2 at ☐ CO2 Retention >2L/min

☐ Other

COPD

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☐ Use of accessory muscles

☐ Wheezing

☐ Dyspnea on exertion ☐ O2 use

☐ Barrel Chest

☐ Clubbing

☐ XR results

☐ Decreased or prolonged breath sounds

☐ Brinchodilator



☒ **History of hospitalization with Respiratory Arrest** ☐ Use of ventilator ☐ CO2 Retention

☐ Other

**Sleep Apnea**

☐ Describe

☒ **Active**

☐ History of

☐ Rule out

comments

positive sleep studies

☐ **Supported by**

☐ Use of CPAP

☐ Positive sleep studies

☐ History of sleepiness during the day

☐ Heavy snoring / restlessness during sleep

☐ Other

comments

uses home ventilator with O2 at night

**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

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

☒ **Yes**

☐ No

☐ Diagnoses

☐ Abnormal Cardiac Rhythm

☐ Aneurysm

☐ Angina

☐ Atrial Fibrillation

☐ Cardio – Respiratory Failure / Shock

☐ Cardiomyopathy

☒ **Congestive Heart Failure**

☐ Deep Vein Thrombosis

☐ Hyperlipidemia

☒ **Hypertension**

☒ **Ischemic Heart Disease (CAD)**

☒ **Myocardial Infarction**

☐ Peripheral Vascular Disease

☐ Pulmonary Hypertension

☐ Valvular Disease

☐ Other

comments

Hypertension, pacemaker defibrillator placed in 2014, CAD, MI with stent placement

**Congestive Heart Failure**

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Ejection fraction

☐ Cardiomegaly

☐ Orthopnea

☐ DOE

☐ PND

☐ S3

☐ Medications

☐ Peripheral edema

☐ Other

comments

orthopnea 2 pillows at night; EF between 23-25% (add note); DOE, medications

Describe

☐ Diastolic

☐ Systolic

☐ Unknown

comments

unknown

Secondary to Hypertension

☒ Yes

☐ No

Is patient on an ACE or ARB

☒ Yes

☐ No

Is patient on a Beta Blocker

☒ Yes

☐ No

Hypertension

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Physical Exam

☒ Medications

☐ Symptoms

☐ Other

Adequately controlled

☒ Yes

☐ No

☐ UnKnown

Ischemic Heart Disease (CAD)

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☐ Cardiac Cath

☐ History of coronary stent

☐ Diagnosis of angina

☐ Medications

☐ History of CABG

☐ ECG

☐ Other

comments

coronary stent, diagnosis, medications

Myocardial Infarction

Describe

☐ Active (in past 28 days)

☒ History of

☐ Rule out

Supported by

☐ ECG changes

☐ Lab results

☒ History of Hospitalization / Procedure for MI

☒ Medications

☒ Other

Other

Describe

comments

stent placement

Is patient taking a Beta Blocker

☐ Yes

☐ No

Is patient taking

☐ Aspirin  
☐ Other

☐ Plavix

☐ Nitrate

History of Chest Pain

☐ Yes ☒ No

History of Intermittent Claudication

☐ Yes ☒ No

Implanted Pacemaker

☐ Yes ☒ No

Implanted Defibrillator

☒ Yes ☐ No

Describe

☐ Ventricular  
Tachycardia

☐ Asystole

☐ Cardiac Arrest

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

comments

sometimes

Do you follow a special diet?

☒ Yes ☐ No

comments

renal

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

Gall Bladder Disease

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

- ☐ Symptoms  
☐ HIDA Scan  
☐ Other
- ☐ Passing of stones  
☐ MRI
- ☐ ERCP  
☐ Treatment history

comments

gallbladder removal - cholecystectomy

### History of blood in stool

☐ Yes ☒ No

### History of black stools

☐ Yes ☒ No

### History of Heartburn / Dyspepsia

☐ Yes ☒ No

### 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

### 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

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

**Generalized Anxiety Disorder**

↳ **Describe**

☒ **Active**

☐ History of

☐ Rule out

↳ **Supported by**

☐ Symptoms

☐ GAD 7

☒ **Antianxiety medication**

☐ Other

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

☒ **Yes**

☐ No

**Do you worry too much about different things?**

☒ **Yes**

☐ No

**Do you feel afraid that something bad might happen?**

☐ Yes

☒ **No**

**History of headaches**

☒ **Yes**

☐ No

↳ **Symptoms with headaches of**

☐ Visual Changes

☐ Auditory changes

☐ Nausea / vomiting

☐ Sensitivity to light / sound

☒ **None**

**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

comments

renal

**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

comments

states "I just wish I could do more"

## PHQ 2 Score

☒ **< 3**

☐ 3 or more

## Speech

☒ **Normal**

☐ Apraxia

☐ Slurred

☐ Aphasic

## Finger to Nose

☒ **Normal**

☐ Abnormal

## Heel (Shin) to Toe

☐ Normal

☐ Abnormal

comments

deferred

## Thumb to Finger Tips

☒ **Normal**

☐ Abnormal

## Sitting to Standing

☐ Normal

☐ Needs Assistance

☐ Unable

comments

needs assistance - relies heavily on rollator walker and spouse at times, but he is disabled and member needs help in her home.

## 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

difficult

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

☒ Yes ☐ No

### Diagnoses

- |                                                                   |                                                  |
|-------------------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Acute Renal Failure                      | <input type="checkbox"/> BPH                     |
| <input checked="" type="checkbox"/> <b>Chronic Kidney Disease</b> | <input type="checkbox"/> ESRD                    |
| <input type="checkbox"/> Erectile Dysfunction                     | <input type="checkbox"/> Frequent UTI            |
| <input type="checkbox"/> Kidney Stones                            | <input type="checkbox"/> Nephritis or Nephrosis  |
| <input checked="" type="checkbox"/> <b>Urinary Incontinence</b>   | <input checked="" type="checkbox"/> <b>Other</b> |
- Chronic Kidney Disease

### Describe

☒ **Active** ☐ History of ☐ Rule out

### Supported by

☒ **Lab tests** ☐ Calculated GFR X 3 ☐ Other

comments

sees specialists

### 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

comments

yes and heart failure

## Urinary Incontinence

### Describe

☒ **Active** ☐ History of ☐ Rule out

comments

active, lab tests, sees specialists

### Supported by

<input checked="" type="checkbox"/> <b>History</b>	<input checked="" type="checkbox"/> <b>Symptoms</b>	<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

### Related to stress

☒ **Yes** ☐ No

### Related to

☒ **Dribbling** ☐ Urgency ☐ Other

### Describe

☐ Daily ☐ Few times a week ☐ Less than once a week

## Other

### Describe

☒ **Active** ☐ History of ☐ Rule out

comments

active, lab tests, sees specialists

### Supported by

<input checked="" type="checkbox"/> <b>History</b>	<input checked="" type="checkbox"/> <b>Symptoms</b>	<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

member states "I can't get to the bathroom fast enough."

## History of frequency

☐ Yes ☒ No

## 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

### 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

### Osteoarthritis

#### Describe

☒ **Active**

☐ History of

☐ Rule out

#### Supported by

☒ Symptoms
 ☒ Physical Findings
 ☐ Image studies
 ☐ Other

↳ Which joints

comments

left hand

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

comments

yes - primarily left hand

Do you have a problem straightening any joints?

☐ Yes
 ☒ No

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

☒ Yes
 ☐ No

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

☐ Yes
 ☒ No

Do you have constant pain in your bones?

☐ Yes
 ☒ No

Have you had an amputation?

☐ Yes
 ☒ No

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

☒ Yes
 ☐ No

↳ Diagnoses

☒ Basil Cell Carcinoma

☐ Eczema

☐ Skin ulcer

☐ Wound

Basil Cell Carcinoma

↳ Describe

☐ Active

↳ Supported by

☒ History

☐ Medications

☐ Biopsy

☐ Dermatitis

☐ Psoriasis

☐ Urticarial Disease

☐ Other

☒ History of

☐ Rule out

☒ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

Do you have ulcers or wounds that require dressings?

☐ Yes
 ☒ No

Do you have a chronic skin condition?

☐ Yes
 ☒ No

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

- |                                                                       |                                                                            |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------|
| <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"/> <b>Diabetes</b>                        |
| <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

8%

#### And Date

comments

unknown

#### Met with a nurse or dietician for diabetic education

☐ Yes

☒ **No**

#### Met with a diabetic educator

☐ Yes

☒ **No**

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

☐ Yes

☒ **No**

Do you often feel thirsty?

☒ **Yes**
☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

Do you get ulcers on your legs or feet?

☐ Yes

☐ No

Do you feel sluggish?

☐ Yes

☐ No

Do you sweat a lot or constantly feel hot?

☐ Yes ☐ No

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

☐ Yes ☐ No

Have you ever had dialysis?

☐ Yes ☐ No

Is your skin itchy?

☐ Yes ☐ No

Do you test your blood sugar?

☐ Yes ☐ No

Have you lost weight in the past 6 months?

☐ None ☐ 5lbs ☐ 10lbs  
☐ 15lbs ☐ More than 15lbs ☐ 10% of your weight  
 (calculated by assessor)

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

☐ Yes ☐ No

## Cancer

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

## Pain

Does the patient experience pain?

☐ Yes ☐ No

## Vital Signs

### Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
123 (mmHG)	71 (mmHG)	60 (bpm)	21	97.2	95	0

## BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	4 (Inch)	140 (lbs)	24.0

☐ 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
---------------------	--------	----------

### 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
Auscultation of heart:	Normal	Abnormal
Carotid Arteries:	Normal	Abnormal
Abdominal Aorta:	Normal	Abnormal
Pedal Pulses:	Normal	Abnormal
Examination of Arterial Pulses:	Normal	Abnormal



Examination of Edema / Varicosities:	Normal	Abnormal
--------------------------------------	--------	----------

### Lymphatic

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

### Musculoskeletal

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

### Skin

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

### Neurologic

Indicate specific cranial nerve tested

Indicate cranial nerve deficits found

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

### Diabetes

Foot Exam:	Normal	Abnormal
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### Psychiatric

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

### Screenings Needed

Screening	Member	Status	Barcode	Confirm	Screening	Exam Date	Screening	Diagnosi	Commen
-----------	--------	--------	---------	---------	-----------	-----------	-----------	----------	--------

Name	Eligible			Barcode	Completed		Result	s	ts
DIGITAL_RETINAL_EXAM	No	Refused Kit			Select		could not obtain images - pt on home ventilator and positioning/lighting could not obtain good images with face mask on (ventilator )		
HBA1C	No	Refused Kit			Select				
MICROALBUMIN	No	Refused Kit			Select				
FOBT	No	Select			Select				
DEXA	No	Select			Select				
PAD	No	Refused Kit			Select				
LDL	N/A	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.<sup>1-3</sup> For repeated administrations, use of an alternative word list is recommended.

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

Step 2: Clock Drawing

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

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

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

Step 3: Three Word Recall

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

Word List Version : --

Person's Answers: deferred

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

## Home Safety & Personal Goals

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

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

↳ 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?

member states "my whole health."

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

member states "I don't know of anything. I try to walk the best I can, but with my heart and breathing, I'm afraid I will trip over my cords and go down to the ground." Also states, "my legs get so weak, they give right out on me."

### 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 :

80yo female with longstanding history of cardiopulmonary compromise. She has a pacemaker/defibrillator; uses a home ventilator system with continuous 2L O2 for COPD history and history of respiratory arrest. Her PCP has started the referral process for additional assistance with decreased ability to perform her ADLs. I spoke to her PCP Caroline Blevins MD (804-560-0490) to update on the HRA findings which is consistent with difficulties performing her ADLs, increased risk of injury in her current environment, high fall risk, and the inability to remove her ventilator without decreased PaO2 from 95% to 84%. She has issues with bathing, dressing, and cooking. She lives with her spouse who appears disabled and recently underwent surgery so he cannot lift or provide the assistance that this patient needs.

#### 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 :	2021-06-11T13:37
Time exam finished	2021-06-11T15:25
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Provider Signature	 <div>Digitally signed by Brittney Walls, FNP 2021-07-28, 06:27</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?