

HRA Form

Health Plan :	Optima Health
Member Name :	ANGELA D STANLEY
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1975-01-28
Evaluation Date :	2021-7-19 10:00 AM
Visit Type :	

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	ANGELA D STANLEY
Gender	Female
Address	278 DOGWOOD ACRES RD
City	BUMPASS
State	VA
Zip	23024-9998
Date of Birth	1975-01-28
Age(as of date)	46
Marital Status	Divorced
Member Identification Number	900042980*01
HICN	
Phone Number	804/387-8453
Cell Number	804/387-8453,
Alternate Contact Number	804/387-8453,
Email	
Emergency Contact	david Stanley
Phone Number	8043878453
Primary Care Physician	between providers
Phone Number	
PCP Address	
PCP City	
PCP State	

PCP Zip	
PCP County	
Office ID	
Office Name	

### 1. Race

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

### 2. Preferred language

- |  |                                |
|--|--------------------------------|
| <input checked="" type="checkbox"/> <b>English</b> | <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 type="checkbox"/> Completed 12th grade | <input checked="" type="checkbox"/> <b>Attended College</b> |  |

### 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  
[Describe](#)

12. Are you currently a caregiver for someone?

- ☐ Yes      ☒ No

13. Tobacco use

- ☐ Current      ☐ Former      ☒ Never

14. Alcohol Use

- ☐ Current      ☐ Former      ☒ Never

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

- ☐ Yes      ☒ No

16. Do you have a Healthcare Proxy?

- ☐ Yes      ☒ No      ☐ Don't Know

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
Gastroenterologist	Vanessa Patel	"stomach issues", lost 37 lbs, unknown cause
Psychiatrist	Unknown	Bipolar, depression, anxiety

### 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

stomach issues

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

3 ortho surgeries: 2 humerus bone fx. 1 ankle, t12 fx with car accident about 5 years ago

### 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	Cervical Ca	unknown
Father	Lupus	

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	Yes
Breast Exam/Mammography	No
Cervical Screening	Yes
Bone Density	No
Prostate Exam/PSA	Not Applicable
If Diabetic Eye Exam	No
If Diabetic Foot Exam	No
If Diabetic Hgb A1c screen	No
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

comments

REfuses

33. Have you been vaccinated for Pneumonia?

☒ Yes☐ No

☒ Pneumovax

☐ Yes☐ No☒ Unknown

☒ Prevenar

☐ Yes☐ No☒ Unknown

34. Have you been vaccinated for Herpes Zoster?

☐ Yes☒ No

Allergies / Medications

35. Allergies

☒ Yes☐ No

Substance	Reaction
PCN	rash

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
Hypothyroidis	LEVOTHYROXIN	TAB 137MCG	PO = By Mouth	QD	PCM	Taking	Not Taking
Anxiety	CLONAZEPAM	TAB 2MG	PO = By Mouth	BID	Psych	Taking	Not Taking
IBS	DICYCLOMIN E	TAB 20MG	PO = By Mouth	QD	Gastro	Taking	Not Taking
Neuropathy	GABAPENTIN	TAB 800MG	PO = By Mouth	TID	PCM	Taking	Not Taking
Bipolar	CARBAMAZEPIN	TAB 400MG ER	PO = By Mouth	QD	Psych	Taking	Not Taking
GERD	PANTOPRAZOLE	TAB 20MG	PO = By Mouth	QD	Gastro	Taking	Not Taking
Bipolar	VRAYLAR	CAP 4.5MG	PO = By Mouth	QPM	PCM	Taking	Not Taking
ALLERGIES	CETIRIZINE	TAB 10MG	PO = By Mouth	QD	PCM	Taking	Not Taking
Depression	FLUVOXAMINE	TAB 100MG	PO = By Mouth	QD	Psych	Taking	Not Taking
"unknown per Pt"	BENZTROPINE	TAB 1MG	PO = By Mouth	BID	PSych	Taking	Not Taking

36. Over the Counter Medications / Supplements

☐ Yes ☒ No

37. Chronic Use of

☒ None

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

comments

needed for distance

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

Diagnoses

☒ Chronic Post Nasal Drip

☐ Sinus Infections

☐ Nose Bleeds

☐ Other

Chronic Post Nasal Drip

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☐ Medications

☐ Biopsy

☐ Symptoms

☐ Test results

☐ DME

☐ Physical Findings☐ Image studies☐ Other

comments

r/t allergies

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

☒ Yes

☐ No

Diagnoses

☐ Bleeding Gums

☐ Difficulty Swallowing

☐ Difficulty Chewing

☒ Other

Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☐ Medications

☐ Biopsy

☐ Symptoms

☐ Test results

☐ DME

☐ Physical Findings☐ Image studies☐ Other

Other

comments

Full dentures

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes

☒ No

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

☐ Yes

☒ No



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

☐ Yes

☒ No

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

Colon Polyps

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☐ Medications

☐ Biopsy

☐ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

Describe

☒ Benign

☐ Carcinoma in situ

☐ Familial Polyposis

comments

found 1-2 months ago

GERD

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Heartburn / Dyspepsia

☐ Other

☐ Regurgitation

☒ Medications

Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ History

☒ Medications

☐ Biopsy

☐ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

Other

comments

IBS. Experiencing frequent abdominal discomfort making her not want to eat. Currently seeing Gasto for work up. Negative colonoscopy. Just started treating for IBS within the last month. Following up next month

History of blood in stool

☐ Yes

☒ No

History of black stools

☐ Yes

☒ No

History of Heartburn / Dyspepsia

☒ Yes

☐ No

☒ Describe  
☐ Occasionally ☒ **Chronic**

History of Vomiting or Regurgitation  
☐ Yes ☒ **No**

History of pain after eating  
☒ **Yes** ☐ No

☒ Describe  
☐ Right upper quadrant ☒ **Epigastric** ☐ Left upper quadrant  
☐ Right lower quadrant ☐ Left lower quadrant

History of Jaundice  
☐ Yes ☒ **No**

Do you follow a special diet?  
☐ Yes ☒ **No**

Do you have frequent abnormal abdominal pain?  
☒ **Yes** ☐ No

Do you have intermittent nausea or vomiting?  
☒ **Yes** ☐ No

Do you have trouble with constipation?  
☒ **Yes** ☐ No

Does diarrhea limit your ability to get out of the room or socially?  
☒ **Yes** ☐ No

Do you see blood in your urine?  
☐ Yes ☒ **No**

Do you have Frequent Stomach Pain  
☒ **Yes** ☐ No

**Bowel Movements**  
☐ Normal ☒ **Abnormal**  
☒ If abnormal  
☐ Constipation ☒ **Diarrhea** ☐ Bowel Incontinence

**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 Hemorrhage  
☐ Cerebral Palsy ☐ Delusional Disease  
☐ Dementia ☒ **Depression**

☐ Drug Dependence

☒ **Generalized Anxiety Disorder**

☐ Hemiparesis

☐ Insomnia

☒ **Migraine Headaches**

☐ Muscular Dystrophy

☐ Parkinson's disease

☐ Restless leg syndrome

☐ Seizure Disorder

☐ Stroke

☐ TIA

☐ Other

Bipolar Disorder

Describe

☒ **Active**

Supported by

☐ History of mood swings

Depression

Describe

☒ **Active**

Supported by

☐ Symptoms

Other

Major

☒ **Yes**

Supported by

☐ PHQ 9

Other

Use of ECT

Generalized Anxiety Disorder

Describe

☒ **Active**

Supported by

☐ Symptoms

Other

Migraine Headaches

Describe

☒ **Active**

Supported by

☐ History

☐ 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

History of

☒ **Medication**

☐ Rule out

☐ Other

History of

☐ PHQ 2 / 9

☒ **Use of antidepressant medication**

NO

☐ Hospitalization

☒ **Chronic use of antidepressant medication beyond 6 months**

History of

☐ GAD 7

☒ **Antianxiety medication**

History of

☒ **Symptoms**

☐ Rule out

☐ Medications

☐ Other

comments

sensitivity to light and sound. Not treated with any medications. Tries to just take a nap or sleep while experiencing

**Peripheral Neuropathy**

**Describe**

☒ Active

☐ History Of

☐ Rule out

**Supported by**

☒ Physical findings

☐ EMG / Nerve Conduction studies

☐ Biopsy

☐ Other

comments

neck and back since MVA 5 years ago

**Secondary to Diabetes**

☐ Yes

☒ No

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

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
- ☐ 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
- ☐ Abductor lurch
- ☐ Limp
- ☐ Wide based
- ☐ Ataxic
- ☐ Paretic
- ☐ Shuffling
- ☐ Other (Findings may also apply to Musculoskeletal diagnoses)

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

- ☐ Yes
- ☒ No

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

- ☒ Yes
- ☐ No

Diagnoses

- ☐ Collagen (Connective) Tissue Disease

☒ Extremity Fracture (other than Hip)

☐ Hallux Valgus

☐ Onychomycosis

☐ Osteomyelitis

☐ Pyogenic Arthritis

☐ Spinal Stenosis

☐ Tinea Pedis

☐ Degenerative Disc Disease

☐ Gout

☐ Hammer Toes

☐ Osteoarthritis

☐ Osteoporosis

☐ Rheumatoid Arthritis

☐ Systemic Lupus Erythematosus

☐ Other
- Extremity Fracture (other than Hip)

- ↳ Describe
  - ☐ Active
- ↳ Supported by
  - ☒ **History**
  - ☐ Medications
  - ☐ Biopsy
- ↳ Describe
  - ☒ **Traumatic**
- ↳ Describe
  - ☐ Shoulder
  - ☐ Wrist
  - ☐ Tibia
  - ☐ Foot
- ↳ Current (within 12 weeks)
  - ☐ Yes
  - ☒ **No**
- ↳ Describe fracture/s

comments

10 years ago right humerous fx

### History / Finding of non- extremity Fracture

☐ Yes ☒ **No**

### History / Finding of Hip Fracture / Dislocation

☐ Yes ☒ **No**

### History / Finding of Vertebral Fracture

☒ **Yes** ☐ No

- ↳ Describe
  - ☐ Active (within 12 weeks)
- ↳ Supported by
  - ☒ **Hospitalization**
  - ☐ Image studies
  - ☐ Surgery
- ↳ Describe
  - ☒ **Traumatic**
  - ☐ Pathological
- ↳ Spinal Cord Injury
  - ☐ Yes
  - ☒ **No**
- ↳ Describe vertebrae/s and fracture type
  - T12 fx. No treatment, just observation

### Do you have any swelling of your joints?

☒ **Yes** ☐ No

comments

hands and ankles

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

☒ **Yes** ☐ No

### Do you have pain in your joints?

☒ **Yes** ☐ No

### Do you have a problem straightening any joints?

☐ Yes ☒ **No**

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

☒ **Yes** ☐ No

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

☒ **Yes** ☐ No

Do you have constant pain in your bones?

- ☐ Yes
- ☒ No

Have you had an amputation?

- ☐ Yes
- ☒ No

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

- ☐ Yes
- ☒ No

Endocrine Problems

- ☒ Yes
- ☐ No

Diagnoses

- ☐ Chronic Kidney Disease secondary 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

Hypothyroidism

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ Weight gain
- ☐ Depression
- ☐ Fatigue
- ☒ Treatment for hypothyroidism
- ☐ Hair changes
- ☐ Lab data

☐ Other

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
(mmHG)	(mmHG)	(bpm)				0

### BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	2 (Inch)	176 (lbs)	32.2

☒ 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
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Palpation of the face and sinuses:	Normal	Abnormal
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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 trubينات:	Normal	Abnormal
Inspection of lips, teeth and gums:	Normal	Abnormal

Comment: Lips appear normal, full dentures present

Examination of oropharynx:	Normal	Abnormal
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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
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## Musculoskeletal

Examination of gait and station:	Normal	Abnormal
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Comment: UTA

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

UTA

Indicate cranial nerve deficits found

UTA

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

## Diabetes

Foot Exam:	Normal	Abnormal
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## Psychiatric

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

## Screenings Needed

Screening Name	Member	Status	Barcode	Confirm Barcode	Screening	Exam Date	Screening Result	Diagnoses	Comments
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	Eligible				Comple ted				
DIGITAL_ RETINAL _EXAM	No	Select			No				Virtual Visit
HBA1C	No	Select			No				Virtual Visit
MICROAL BUMIN	No	Select			No				Virtual Visit
FOBT	No	Select			No				Virtual Visit
DEXA	N/A	Select			No				Virtual Visit
PAD	No	Select			No				Virtual Visit
LDL	No	Select			No				Virtual Visit

Mini-Cog

### 39. Mini- Cog (see attached sheet)

#### Step 1: Three Word Registration

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

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

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

#### Step 2: Clock Drawing

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

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

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

#### Step 3: Three Word Recall

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

Word List Version : 1

Person’s Answers: banana, sunrise, chair

Word Recall :	3 Points	1 point for each word spontaneously recalled without cueing. Home Safety Yes
Clock Draw :	-- 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 :	3 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?

no

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

no

#### 44. Have you ever physically or felt emotionally abused by someone

- ☐ Yes
 ☒ No

#### 45. Feeling like harming others or yourself

- ☐ Yes
 ☒ No

#### 46. Are you afraid of anyone or is anyone hurting you?

- ☐ Yes
 ☒ No

#### Patient Summary

#### Assessors Comments :

Member gives consent and visit performed virtually . Blanks in document due to

limitations of client and/or nature of virtual visit and completed to best of ability. Started the visit with video connection, but there are storms in the area and the connection kept weakening and video would stop working. Able to complete most of assessment, but could not assess, NEuro, musc/skel and clock draw of mini cog d/t poor connections.

Identity confirmed by DOB, Name and Address

Unable to palpate or inspect nasal mucosa, septum and turbinates, inspect teeth and gums, examine oropharynx, examine thyroid, percuss or palpate chest, auscultate lungs, perform any cardiovascular, lymphatic, skin and subcutaneous tissues or full cranial nerve assessment as this is not appropriate or possible with virtual visits and low resolution visual quality.

Per pt she was diagnosed with Lupus about 12 years ago, but did not receive any kind of treatment. PCM said Lupus screening bloodwork negative. Recently having increased muscle/joint discomfort and swelling. Requested Rheumatology referral for further eval. Waiting for approval to schedule

Recommended they keep routine visits with PCM for continued medical care, treatment, and preventative care-pt agrees

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 :	2021-07-19T10:00
Time exam finished	2021-07-19T11:00
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input checked="" type="checkbox"/>
Provider Signature	<div><div><i>S. Darrow, NP.</i></div><div>Digitally signed by Sarah Darrow, FNP 2021-07-27, 10:56</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?