

HRA Form

Health Plan :	Optima Health
Member Name :	LORETTA WATSON
Evaluator Name :	Shante Tucker, NP
Assessment Type :	Health Risk Assessment
DOB :	1954-07-20
Evaluation Date :	2021-7-13 12:00 PM
Visit Type :	In Person

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	LORETTA WATSON
Gender	Female
Address	5161 RACE POINTE PL
City	WOODBIDGE
State	VA
Zip	22193-9998
Date of Birth	1954-07-20
Age(as of date)	67
Marital Status	Widowed
Member Identification Number	900045751*01
HICN	
Phone Number	240/565-9270
Cell Number	240/565-9270, 240/565-9270
Alternate Contact Number	240/565-9270, 240/565-9270,
Email	
Emergency Contact	Letitia Perry
Phone Number	240-565-0270
Primary Care Physician	FAROUGH, ATOUSSA MD
Phone Number	703/897-4700
PCP Address	12731 MARBLESTONE DR
PCP City	WOODBIDGE
PCP State	VA

PCP Zip	22192
PCP County	
Office ID	165925
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 type="checkbox"/> Non-Hispanic | <input checked="" type="checkbox"/> Other Ethnicity |
| <input type="checkbox"/> Prefer not to say | | |

comments

Black

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

comments

2 years of 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

comments

children, grandchildren

11. Who do you currently live with?

- ☐ Alone
 ☐ Spouse
 ☐ Partner
- ☐ Relative
 ☒ **Family**
☐ Friend
- ☐ Personal Care Worker

12. Are you currently a caregiver for someone?

- ☐ Yes
 ☒ **No**

13. Tobacco use

- ☐ Current
 ☒ **Former**
☐ Never
- ☐ Type
 ☒ **Cigarettes**
☐ Cigars
 ☐ Chewing Tobacco
- ☐ Vaping
 ☐ Other
- ☐ How Many
 ☒ **1 - 3 a day**
☐ 1/2 a pack
 ☐ 1 pack
- ☐ More than 1 pack
 ☐ Other

comments member states she smoked socially, not daily, quit smoking "many years ago"

14. Alcohol Use

☐ Current ☐ Former ☒ **Never**

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

☐ Yes ☒ **No**

16. Do you have a Healthcare Proxy?

☒ **Yes** ☐ No ☐ Don't Know

↳ Name

Letitia Perry

↳ Relationship

daughter

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

comments discussed importance of AD and where to find resources

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

comments "we just made the food stretch"

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
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Comment: member requires full assistance, member lives at home with children, son present during time of visit and assists member with all ADLs

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

↳ 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
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↳ 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**

↳ Describe
hospital bed

21. Are you currently seeing any specialists?

- ☒ **Yes**
☐ No

Medical Specialty	Specialist	For
Ophthalmologist	Dr Babur Lateef	cataracts, diabetic eye exams
Podiatrist	Dr Douglas Stabile	nail clipping, diabetic foot care

22. In the past 12 months how many times have you?

A. Seen your PCP	None	1	2	3	4	5 or more
------------------	------	---	---	---	---	-----------

Comment: telehealth visits

B. Visited the Emergency Room	None	1	2	3	4	5 or more
C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
D. Been in a nursing home	None	1	2	3	4	5 or more
E. Had Surgery	None	1	2	3	4	5 or more

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

- ☒ **Yes**
☐ No

↳ Describe

2013 - CVA

2013 - PEG tube inserted, removed a few months later

2020 - Ovarian cancer, stage 2, received chemo and Radiation, surgical

procedure (unsure of what done exactly)

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
--------------	-----	----	---------

Comment: for ovarian cancer, early 2020

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	"hole in heart"	MI - age 43
Father	DM, HTN, HLD	prostate cancer - age 80s
Sibling1	no other health conditions	breast cancer, 40s
Sibling2	breast cancer, stage 1	

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	No

Breast Exam/Mammography	Yes
Cervical Screening	Yes
Bone Density	Don't Know
Prostate Exam/PSA	Not Applicable
If Diabetic Eye Exam	Yes
If Diabetic Foot Exam	Yes
If Diabetic Hgb A1c screen	Yes
Lipid Panel	Yes

28. Last colonoscopy if more than 2 years ago

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

comments discussed importance of colonoscopy, encouraged member to f/u with pcp

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

comments member is unsure, discussed importance of screening and to f/u with pcp

32. Do you get Flu Vaccine each year?

- ☒ **Yes**
☐ No

33. Have you been vaccinated for Pneumonia?

- ☐ Yes
 ☒ **No**

comments discussed purpose of vaccine and importance of following up with pcp

34. Have you been vaccinated for Herpes Zoster?

- ☐ Yes
 ☒ **No**

comments discussed purpose of vaccine and importance of following up with pcp

Allergies / Medications

35. Allergies

- ☐ Yes
 ☒ **No**

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
	SCOPOLAMI	DIS	Select	Select		Taking	Not Taking

	NE	1MG/3DAY					
DM	NOVOLIN	INJ 70/30	SQ = Subcutaneous	TID		Taking	Not Taking
DM	METFORMIN	TAB 500MG	PO = By Mouth	BID		Taking	Not Taking
HTN	LOSARTAN POT	TAB 100MG	PO = By Mouth	QD		Taking	Not Taking
HLD, CAD	SIMVASTATIN	TAB 40MG	PO = By Mouth	QD		Taking	Not Taking
HTN	ATENOLOL	TAB 100MG	PO = By Mouth	QD		Taking	Not Taking
HTN	TERAZOSIN	CAP 5MG	PO = By Mouth	QD		Taking	Not Taking
HTN	AMLODIPINE	TAB 10MG	PO = By Mouth	QD		Taking	Not Taking
	CEPHALEXIN	CAP 500MG	Select	Select		Taking	Not Taking
depression	SERTRALINE	TAB 50MG	PO = By Mouth	QD		Taking	Not Taking
CAD, post CVA	clopidogrel	75 mg	PO = By Mouth	QD		Taking	Not Taking

36. Over the Counter Medications / Supplements

☐ Yes ☒ No

37. Chronic Use of

☐ None

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

38. Medication Compliance and Knowledge of Use and Disease

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

Review of Systems and Diagnoses

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

☒ Yes ☐ No

 Diagnoses

- ☒ **Cataracts**
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Disease

- ☐ Difficulty with vision
- ☐ Hyperopia
- ☐ Myopia
- ☐ Others

Cataracts

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

- ☐ History
- ☐ Medications
- ☐ Biopsy

- ☒ **Symptoms**
- ☐ Test results
- ☐ DME

- ☐ Physical Findings
- ☐ Image studies
- ☐ Other

Secondary to Diabetes

☐ Yes

☒ **No**

Do you wear glasses or contacts?

☐ 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**

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

☒ **Yes**

☐ No

Diagnoses

☐ Bleeding Gums

☐ Difficulty Chewing

☒ **Difficulty Swallowing**

☒ **Other**

comments

dysphasia, late effect of stroke

Difficulty Swallowing

Describe

☒ **Active**

☐ History of

☐ Rule out

Have you had a stroke

☒ **Yes**

☐ No

Do you eat a special diet

☒ **Yes**

☐ No

comments

Soft diet

Other

Describe

☒ **Active**

☐ History of

☐ Rule out

↳ **Supported by**

- ☐ History
- ☐ Medications
- ☐ Biopsy

- ☒ **Symptoms**
- ☐ Test results
- ☐ DME

- ☒ **Physical Findings**
- ☐ Image studies
- ☐ Other

↳ **Other**

comments

dysphasia, late effect of stroke

Neck Problems (parotid Disease, Carotid Stenosis, Other)

- ☐ Yes
- ☒ **No**

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

- ☒ **Yes**
- ☐ No

↳ **Diagnoses**

- | | |
|--|--|
| <input type="checkbox"/> Acute Pulmonary Embolism | <input type="checkbox"/> Acute Upper Respiratory Infection |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic Pulmonary Embolism |
| <input type="checkbox"/> Chronic Respiratory Failure | <input type="checkbox"/> Chronic Sputum Production |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Hypoventilation secondary to Obesity | <input type="checkbox"/> Hypoxemia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pulmonary Fibrosis |
| <input type="checkbox"/> Respirator Dependence/
Tracheostomy Status | <input type="checkbox"/> Respiratory Arrest |
| <input type="checkbox"/> Sarcoidosis | <input checked="" type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Other | |

Sleep Apnea

↳ **Describe**

- ☒ **Active**

- ☐ History of

- ☐ Rule out

↳ **Supported by**

- ☒ **Use of CPAP**

- ☐ Positive sleep studies

- ☐ History of sleepiness during the day

- ☐ Heavy snoring / restlessness during sleep

- ☐ Other

Use of Oxygen

- ☐ Yes
- ☒ **No**

Shortness of breath

- ☐ Yes
- ☒ **No**

Wheezing

- ☐ Yes
- ☒ **No**

Chronic Cough

- ☐ Yes
- ☒ **No**

Patient requires durable medical equipment

- ☐ Yes
- ☒ **No**

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

☒ Yes

☐ No

↳ Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Abnormal Cardiac Rhythm | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Cardio – Respiratory Failure / Shock | <input type="checkbox"/> Cardiomyopathy |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Deep Vein Thrombosis |
| <input checked="" type="checkbox"/> Hyperlipidemia | <input checked="" type="checkbox"/> Hypertension |
| <input checked="" type="checkbox"/> Ischemic Heart Disease (CAD) | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Valvular Disease | <input type="checkbox"/> Other |

Hyperlipidemia

↳ Describe

- | | | |
|---|-------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|---|-------------------------------------|-----------------------------------|

↳ Supported by

- | | | |
|--------------------------------------|---|--------------------------------|
| <input type="checkbox"/> Lab results | <input checked="" type="checkbox"/> Medication | <input type="checkbox"/> Other |
|--------------------------------------|---|--------------------------------|

↳ Is patient on Statin

- | | |
|--|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|--|-----------------------------|

Hypertension

↳ Describe

- | | | |
|---|-------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|---|-------------------------------------|-----------------------------------|

↳ Supported by

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Physical Exam | <input checked="" type="checkbox"/> Medications | <input type="checkbox"/> Symptoms |
| <input type="checkbox"/> Other | | |

↳ Adequately controlled

- | | | |
|------------------------------|---|----------------------------------|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | <input type="checkbox"/> UnKnown |
|------------------------------|---|----------------------------------|

comments

BP elevated during time of visit 185/89

Ischemic Heart Disease (CAD)

↳ Describe

- | | | |
|---|-------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|---|-------------------------------------|-----------------------------------|

↳ Supported by

- | | | |
|--|--|--|
| <input type="checkbox"/> Cardiac Cath | <input type="checkbox"/> History of coronary stent | <input type="checkbox"/> Diagnosis of angina |
| <input checked="" type="checkbox"/> Medications | <input type="checkbox"/> History of CABG | <input type="checkbox"/> ECG |
| <input type="checkbox"/> Other | | |

History of Chest Pain

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

History of Intermittent Claudication

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

Implanted Pacemaker

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

Implanted Defibrillator

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

Do you have abnormal heart beats?

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

Does your heart race?

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> 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

left foot

Do you follow a special diet?

☒ Yes ☐ No

comments

soft diet

Do you have headaches?

☐ Yes ☒ No

Do you feel light headed when you stand up?

☐ Yes ☒ No

Gastrointestinal Problems (Ulcer, Reflux, Hiatal Hernia, Colitis, Other)

☐ Yes ☒ No

Bowel Movements

☒ Normal ☐ Abnormal

Abdominal Openings

☐ Yes ☒ No

Rectal Problems

☐ Yes ☒ No

Last Bowel Movement

☐ Today ☒ 1-3 days ago ☐ >3 days ago

Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)

☒ Yes ☐ No

Diagnoses

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

- ☒ **Stroke**
- ☐ TIA
- ☒ **Other**
- ☐ Subdural Hematoma
- ☐ Traumatic Brain Injury

comments hemiplegia, left side, non-dominant, late effect of stroke

Depression

Describe

- ☒ **Active**
- ☐ History of
- ☐ Rule out

Supported by

- ☐ Symptoms
- ☐ PHQ 2 / 9
- ☒ **Use of antidepressant medication**

- ☐ Other

Major

- ☐ Yes
- ☒ **NO**

Stroke

Describe

- ☒ **Active**
- ☐ History of
- ☐ Rule out

Supported by

- ☒ **Hospitalization**
- ☐ Image study
- ☐ Physical findings
- ☐ Sensory findings
- ☐ Other

Other

Describe

- ☒ **Active**
- ☐ History of
- ☐ Rule out

Supported by

- ☐ History
- ☐ Medications
- ☐ Biopsy
- ☐ Symptoms
- ☐ Test results
- ☐ DME
- ☒ **Physical Findings**
- ☐ Image studies
- ☐ Other

Other

comments hemiplegia, left side, non-dominant, late effect of stroke

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

comments "I feel that way sometimes"

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

comments

left hemiplegia, bed bound

Do you have trouble swallowing your food?

☒ Yes

☐ No

comments

dysphagia, late effect of stroke, soft diet

Do you have trouble making people understand you when you speak?

☒ Yes

☐ No

comments

dysphasia, late effect of stroke

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**
☒ **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**

comments

dysphasic

Finger to Nose

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

Heel (Shin) to Toe

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

Thumb to Finger Tips

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

Sitting to Standing

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

comments

member is bed bound

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

- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Limp | <input type="checkbox"/> Wide based |
| <input type="checkbox"/> Abductor lurch | <input type="checkbox"/> Paretic | <input type="checkbox"/> Shuffling |
| <input type="checkbox"/> Ataxic | <input checked="" type="checkbox"/> Other (Findings may also apply to Musculoskeletal diagnoses) | |

comments

member is bed bound

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 type="checkbox"/> Chronic Kidney Disease | <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"/> Urinary Incontinence | <input type="checkbox"/> Other |

Urinary Incontinence

Describe

- ☒ Active

- ☐ History of ☐ Rule out

Supported by

- ☐ History
☐ Medications
☐ Biopsy

- ☒ Symptoms ☐ Physical Findings
☐ Test results ☐ Image studies
☐ DME ☐ Other

Related to stress

- ☐ Yes

- ☒ No

Describe

- ☒ Daily

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

History of frequency

- ☐ Yes ☒ No

History of Nocturia

- ☐ Yes ☒ No

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

Endocrine Problems

☒ Yes ☐ No

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Chronic Kidney Disease secondary to Diabetes | <input checked="" type="checkbox"/> Coronary Artery Disease and Diabetes |
| <input type="checkbox"/> Cushing's Disease | <input checked="" type="checkbox"/> Diabetes |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Secondary Hyperparathyroidism |
| <input checked="" 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 |

Coronary Artery Disease and Diabetes

Describe

☒ **Active** ☐ History of ☐ Rule out

Supported by

<input type="checkbox"/> History	<input type="checkbox"/> Symptoms	<input type="checkbox"/> Physical Findings
<input checked="" 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

Is patient on a statin

☒ Yes ☐ No

Is patient on an aspirin

☐ Yes ☒ No

Diabetes

Describe

☒ **Active** ☐ History of ☐ Rule out

Supported by

<input type="checkbox"/> Symptoms	<input type="checkbox"/> Physical findings	<input type="checkbox"/> Lab tests
<input checked="" type="checkbox"/> Medications	<input type="checkbox"/> Other	

Type

☐ Type 1 ☒ **Type 2** ☐ Gestational

Most recent Hb A1C, value

comments

unknown

And Date

comments

unknown

Met with a nurse or dietician for diabetic education

☐ Yes ☒ No

Met with a diabetic educator

☐ Yes ☒ No

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)

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

☐ Yes ☒ No

Cancer

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

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☐ Physical findings

☐ Hospitalization

☒ Treatments

☐ Lab tests

☐ Imaging studies

☒ Surgery

☐ Biopsy

☐ Other

Type

☐ Brain

☐ Head

☐ Neck

☐ Breast

☐ Lung

☐ Esophagus

☐ Stomach

☐ Liver

☐ Pancreas

☐ Colon

☐ Rectum

☐ Kidney

☐ Bladder

☒ Ovaries

☐ Uterus

☐ Prostate

☐ Bone

☐ Blood

☐ Lymph Nodes

☐ Skin

☐ Other

↳ Specific type/s

↳ Stage or Classification specific to the cancer

stage 2 - in remission

Active treatment

☐ Yes

☒ No

History / Finding of Metastasis

☐ Yes

☒ No

Do you see a specialist?

☐ 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
185 (mmHG)	89 (mmHG)	61 (bpm)	15	97.3	97	0

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	4 (Inch)	250 (lbs)	42.9

- ☐ 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: edentulous

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

Comment: 2+ pitting edema, LLE

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: member is bedbound

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

Comment: hemiplegia left side, decreased ROM LUE and LLE

Assessment of stability:	Normal	Abnormal
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Comment: member is bed bound

Assessment of muscle strength/tone:	Normal	Abnormal
-------------------------------------	--------	----------

Comment: hemiplegia, left side, unable to lift left leg or raise left arm

Skin

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

Neurologic

Indicate specific cranial nerve tested

1-8, 10-12

Indicate cranial nerve deficits found

11 - member unable to shrug left shoulder

Romberg Test	Normal	Abnormal
Comment: member unable to stand		
Examination of reflexes:	Normal	Abnormal
Comment: decreased reflexes, left side		
Examination of sensation:	Normal	Abnormal
Coordination:	Normal	Abnormal
Comment: member bed bound		

Diabetes

Foot Exam:	Normal	Abnormal
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Psychiatric

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

Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnosis	Comments
DIGITAL_RETINAL_EXAM	Yes	Refused Kit			Select				attempted eye exam x4, member unable to keep eyes looking straight and unable to sit up completely.
HBA1C	Yes	Left Kit	77010149	77010149	Select			DM	
MICROALBUMIN	Yes	Refused Kit			Select				member is incontinent, uses pads, unable to void in cup
FOBT	Yes	Left Kit	330279850	330279850	Select			screening for fecal occult blood	

DEXA	Select	Select			Select				
PAD	Yes	Refused Kit			Select				member unable to lay flat, unable to straighten left arm due to hemiplegia
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.1-3 For repeated administrations, use of an alternative word list is recommended.

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

Step 2: Clock Drawing

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

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

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

Step 3: Three Word Recall

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

Word List Version : 1

Person's Answers: banana, sunrise, chair

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

Home Safety & Personal Goals

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

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

41. Home Safety

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

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

"physical therapy on my left side so I can walk"

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

"Go up and down the stairs"

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 pleasant during time of visit. Son and and granddaughter present. Member tolerated visit well. BP elevated during visit, member asymptomatic. Son stated she had just taken her medication prior to the visit and she often has "white coat syndrome." Son states they do have a BP machine at home, educated on importance of monitoring BP and f/u with pcp if BP remains elevated. Member verbalized understanding. Member unable to tolerate eye exam and PAD exam. Member in hospital bed at home, bed bound. Member unable to sit up straight and keep eyes straight. Member unable to lay flat for PAD testing, unable to straighten left arm.

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 :	2021-07-13T12:00
Time exam finished	2021-07-13T13:06
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Provider Signature	 
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?