

HRA Form

Health Plan :	Optima Health
Member Name :	VALE M JOHNSON
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1965-08-03
Evaluation Date :	2021-7-18 02:00 PM
Visit Type :	

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	VALE M JOHNSON
Gender	Female
Address	1518 BRIARFIELD RD
City	HAMPTON
State	VA
Zip	23666-9998
Date of Birth	1965-08-03
Age(as of date)	55
Marital Status	Married
Member Identification Number	900045888*01
HICN	
Phone Number	253/282-5975
Cell Number	253/282-5975,
Alternate Contact Number	253/282-5975,
Email	
Emergency Contact	Matt Johnson
Phone Number	8177218698
Primary Care Physician	MCGAVERN, MEGAN B DO
Phone Number	757/234-4285
PCP Address	12652 JEFFERSON AVE
PCP City	NEWPORT NEWS
PCP State	VA

PCP Zip	23602
PCP County	
Office ID	118380
Office Name	Riverside Brentwood

### 1. Race

- ☒ **Caucasian**
☐ African American
 ☐ Asian  
☐ Latino
 ☐ Native American
 ☐ Native Hawaiian or other Pacific Islander  
☐ Alaskan Native
 ☐ Other

### Patient's Ethnicity

- ☐ Hispanic
 ☒ **Non-Hispanic**
☐ Other Ethnicity  
☐ Prefer not to say

### 2. Preferred language

- ☒ **English**
☐ Other

## Previously Documented Conditions

## Covid Screening

In the last 14 days, have you:

Traveled internationally?	Yes	No
Had known exposure to anyone diagnosed with Corona virus (COVID-19)	Yes	No
Had close contact with someone who has traveled to a high risk area?	Yes	No
Developed Fever?	Yes	No
Developed Cough?	Yes	No
Developed Flu like symptoms?	Yes	No
Developed Shortness of breath?	Yes	No

## Self-Assessment and Social History

### 3. How much school have you completed?

- ☐ Less than 3rd grade
 ☐ Completed 3rd grade
 ☒ **Completed 8th grade**  
☐ Completed 12th grade
 ☐ Attended College

comments

through 11th

4. When you get written information at a doctor's office would you say it is

☐ Very difficult

☐ Somewhat difficult

☐ Easy

☐ Very easy to understand
5. When you read the instructions on a prescription bottle would you say that it is

☐ Very difficult

☐ Somewhat difficult

☐ Easy

☒ Very easy to understand
6. How confident are you in filling out medical forms by yourself?

☐ Not at All Confident

☐ Not Very Confident

☐ Confident

☒ Very Confident
7. How would you rate your health compared to other persons your age?

☐ Excellent

☐ Good

☐ Fair

☒ Poor
8. During past 3 months, has your physical and or emotional health limited your social activities with family, friends, neighbours or groups?

☐ Often

☐ Sometimes

☐ Almost Never

☒ Never
9. Where do you currently live?

☒ Home

☐ Apartment

☐ Assisted Living

☐ Nursing Home

☐ Homeless

☐ Other
10. Do you have someone you can rely on to help if you are sick or have problems you need to discuss?

☒ Yes

☐ No
11. Who do you currently live with?

☐ Alone

☐ Spouse

☐ Partner

☐ Relative

☒ Family

☐ Friend

☐ Personal Care Worker
12. Are you currently a caregiver for someone?

☐ Yes

☒ No
13. Tobacco use

☐ Current

☒ Former

☐ Never

Type

☒ Cigarettes

☐ Cigars

☐ Chewing Tobacco

☐ Vaping

☐ Other

How Many

☐ 1 - 3 a day

☒ 1/2 a pack

☐ 1 pack

☐ More than 1 pack

☐ Other

comments

until 2014 when diagnosed with pancreatic ca

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
 ☐ Cane
 ☒ **Walker**
☐ Prosthesis

☐ Wheel Chair
 ☐ Bedside Commode
 ☐ Urinal

☐ Bed Pan
 ☐ Other

21. Are you currently seeing any specialists?

☒ **Yes**
☐ No

Medical Specialty	Specialist	For
-------------------	------------	-----

Oncologist	riverside	
Pulmonologist	riverside	alpha 1 antitrypsin

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

Comment: HH RN comes to do infusion weekly

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

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

Family History

26. Family History

☒ Yes ☐ No

Family Member	Medical Condition	Cause of Death
Mother	stroke, alpha 1 antitrypsin deficiency, liver ca	MI
Father	mesothelioma, DM, alpha 1 antitrypsin deficiency	unknown
Sibling1	alpha 1 antitrypsin deficiency	n/a

## Preventive Care

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

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

### 28. Last colonoscopy if more than 2 years ago

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

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

☒ Yes
 ☐ No
 ☐ NA

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

☐ Yes
 ☐ No
 ☒ NA

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

☒ Yes
 ☐ No
 ☐ NA

### 32. Do you get Flu Vaccine each year?

☒ Yes
 ☐ No

### 33. Have you been vaccinated for Pneumonia?

☒ Yes
 ☐ No

☐ Pneumovax
 ☐ Yes
 ☐ No
 ☒ Unknown

☐ Prevenar
 ☐ Yes
 ☐ No
 ☒ Unknown

### 34. Have you been vaccinated for Herpes Zoster?

☐ Yes

☒ No

Allergies / Medications

35. Allergies

☒ Yes

☐ No

Substance	Reaction
bees	anaphylaxis
PCN	anaphylaxis
narcotic- percocet, darvocet, tramadol	rash, mood swings
cortisone injection	swelling

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
Alpha 1	SPIRIVA	SPR 2.5MCG	PO = By Mouth	QD		Taking	Not Taking
Alpha 1	PROLASTIN-C	INJ 1000MG	IV = Intravenous	QW		Taking	Not Taking
	BUSPIRONE	TAB 7.5MG	Select	Select		Taking	Not Taking
	NYSTATIN	SUS 100000	Select	Select		Taking	Not Taking
Alpha 1	ALBUTEROL	AER HFA	PO = By Mouth	PRN		Taking	Not Taking
Alpha 1	SYMBICORT	AER 160-4.5	PO = By Mouth	BID		Taking	Not Taking
Alpha 1	PREDNISON E	TAB 10MG	PO = By Mouth	PRN		Taking	Not Taking
Alpha 1	duoneb	neb	PO = By Mouth	BID		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	Yes	No

you stop taking it?		
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

- |   |   |
|---|---|
| <input type="checkbox"/> Cataracts            | <input checked="" type="checkbox"/> <b>Difficulty with vision</b> |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Hyperopia                                |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Myopia                                   |
| <input type="checkbox"/> Retinal Disease      | <input type="checkbox"/> Others                                   |

comments

astigmatism

#### Difficulty with vision

##### Describe

☒ **Active** ☐ History of ☐ Rule out

##### Legally Blind

☐ Yes ☒ **No**

### Do you wear glasses or contacts?

☒ Yes ☐ No

comments

readers- needs new glasses but could not afford what they wanted for glasses

#### Do you have trouble seeing even with glasses?

☒ Yes ☐ No

#### Do you need help in and out of the house because you can't see well?

☐ Yes ☒ **No**

### Do you have problems seeing at night?

☐ Yes ☒ **No**

### Do you have eye pain?

☐ Yes ☒ **No**

### Do you have problems with tearing?

☐ Yes ☒ **No**

### Do you have a problem with dry eye?

☐ Yes ☒ **No**

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

☒ Yes ☐ No

#### Diagnoses

- |  |  |
|--|--|
| <input type="checkbox"/> Difficulty with Hearing | <input type="checkbox"/> Legally Deaf              |
| <input type="checkbox"/> Tinnitus                | <input checked="" type="checkbox"/> <b>Vertigo</b> |
| <input type="checkbox"/> Other                   |  |

comments

Meniere's

#### Vertigo

##### Describe

☒ **Active** ☐ History of ☐ Rule out

##### Supported by

☐ History ☒ **Symptoms** ☐ 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         |

↳ Do you lose your balance

- ☒ Yes ☐ No

comments

no recent falls

Do you have trouble hearing when people talk to you?

- ☐ Yes ☒ No

Do you wear a hearing aid?

- ☐ Yes ☒ No

Do you read lips?

- ☒ Yes ☐ No

Do you have ear pain or drainage?

- ☐ Yes ☒ No

Do you ever get dizzy?

- ☐ Yes ☒ No

Nose Problems (Nose Bleeds, Sinus infections, Other)

- ☐ Yes ☒ No

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

- ☒ Yes ☐ No

↳ Diagnoses

- |  |  |
|--|--|
| <input type="checkbox"/> Bleeding Gums                 | <input checked="" type="checkbox"/> Difficulty Chewing |
| <input type="checkbox"/> Difficulty Swallowing         | <input type="checkbox"/> Other                         |
| <input checked="" type="checkbox"/> Difficulty Chewing |  |

↳ Describe

- ☒ Active ☐ History of ☐ Rule out

↳ Because of pain

- ☒ Yes ☐ No

↳ Because you wear partial or complete dentures

- ☐ Yes ☒ No

comments

missing/broken

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                |

- ☐ Respirator Dependence/  
Tracheostomy Status

☐ Respiratory Arrest
- ☐ Sarcoidosis

☐ Sleep Apnea
- ☒ Other

☐ History of

☐ Rule out
- ☐ Other

☐ Symptoms

☒ Physical Findings
- ☐ Describe

☐ Test results

☐ Image studies
- ☒ Active

☐ DME

☐ Other
- ☐ Supported by

☐ Other
- ☐ History

☐ Biopsy
- ☐ Medications

comments

Alpha 1 antitrypsin

Use of Oxygen

- ☒ Yes

☐ No
- ☐ Describe

☐ Continuous

☐ Day
- ☐ PRN

☒ Night
- ☐ Litres / Min

4L, PM/PRN

Shortness of breath

- ☒ Yes

☐ No

comments

cleaning products, smoke, heat/humidity

Wheezing

- ☐ Yes

☒ No

Chronic Cough

- ☐ Yes

☒ No

Patient requires durable medical equipment

- ☒ Yes

☐ No

comments

nebulizer

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

- ☐ 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**

**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**

**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

☐ Ataxic

☐ Limp

☐ Paretic

☐ Other (Findings may also apply to Musculoskeletal diagnoses)

☐ Wide based

☐ Shuffling

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

☐ Yes

☒ No

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

☒ Yes

☐ No

#### 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

#### Other

#### Describe

☒ Active

☐ History of

☐ Rule out

#### Supported by

☒ History

☐ Symptoms

☐ Physical Findings

Medications      Test results      Image studies  
Biopsy      DME      Other

Other

Multiple Sclerosis

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

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

comments

broken rib as a child

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**
  - Diagnoses**
    - ☐ Basil Cell Carcinoma
    - ☐ Eczema
    - ☐ Skin ulcer
    - ☐ Wound
    - ☐ Dermatitis
    - ☒ **Psoriasis**
    - ☐ Urticarial Disease
    - ☒ **Other**
  - Psoriasis**
    - Describe**
      - ☒ **Active**
      - ☐ History of
      - ☐ Rule out
    - Supported by**
      - ☐ History
      - ☐ Medications
      - ☐ Biopsy
      - ☒ **Symptoms**
      - ☐ Test results
      - ☐ Physical Findings
      - ☐ DME
      - ☐ Image studies
      - ☐ Other
    - History of Psoriatic Arthritis**
      - ☐ Yes
      - ☒ **No**
  - Other**
    - Describe**
      - ☒ **Active**
      - ☐ History of
      - ☐ Rule out
- ☐ **No**

- Supported by

☐ History

☐ Medications

☐ Biopsy

☒ Symptoms

☐ Test results

☐ DME

☒ Physical Findings

☐ Image studies

☐ Other
- Other

comments

dry skin due to medications

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

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
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Describe

- ☐ Active
- ☒ History of
- ☐ Rule out

Supported by

- ☐ Physical findings☐ Lab tests☐ Biopsy

☐ Hospitalization☐ Imaging studies☐ Other

☒ Treatments☒ Surgery

Type

- ☐ Brain☐ Breast☐ Stomach☐ Colon☐ Bladder☐ Prostate☐ Lymph Nodes

☐ Head☐ Lung☐ Liver☐ Rectum☐ Ovaries☐ Bone☐ Skin

☐ Neck☐ Esophagus☒ Pancreas☐ Kidney☐ Uterus☐ Blood☐ Other

Specific type/s

unknown

## Stage or Classification specific to the cancer

unknown

## Active treatment

☐ Yes ☒ No

## History / Finding of Metastasis

☐ Yes ☒ No

## Do you see a specialist?

☒ Yes ☐ No

## Provider

Riverside

## Pain

### Does the patient experience pain?

☒ Yes ☐ No

### Is the Pain Acute?

☐ Yes ☒ No

### Is the Pain Chronic?

☒ Yes ☐ No

## Describe

☒ Active

☐ History of

☐ Rule out

## Where

head, stomach, hands, general all over

## Do you take Methadone

☐ Yes ☒ No

## What drug/s do you take for it

does not take pain medications

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

3-4/10

### Is the Patient Undergoing Pain Management Planning?

☐ Yes ☒ No

### Was the patient advised regarding the potential for dependence?

☒ Yes ☐ No

### Is there any evidence of Maladaptive Behavior?

#### Tolerance?

☐ Yes ☒ No

#### Withdrawal?

☐ Yes ☒ No

### Increased usage over a longer period that intended?

☐ Yes ☒ No

### Desire or unsuccessful effort to cut down on use?

☐ Yes

☒ No

Excess time spent in activities to obtain the substance?

☐ Yes

☒ No

Continued use despite Doctor advice or patient knowledge of habituation?

☐ Yes

☒ No

Physical or Psychological Problem related to the substance use?

☐ Yes

☒ No

## Vital Signs

### Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
110 (mmHG)	82 (mmHG)	78 (bpm)	16	97.9	93	4/10

### BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	4 (Inch)	230 (lbs)	39.5

☐ Obesity (BMI 30 – 34.9)

☒ **Moderate Obesity (BMI 35 – 39.9)**
☐ Morbid Obesity (BMI = or > 40)

☐ Malnutrition (BMI < 18.5)

## Exam Review

### Constitutional

General appearance:	Normal	Abnormal
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### Head and Face

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

### 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: missing broken teeth		
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

smile, stick out tongue, puff cheeks, shrug shoulders, move head/eyes side to side and up/down

Indicate cranial nerve deficits found

n/a

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 Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnoses	Comments
DIGITAL_RETINAL_EXAM	No	Select			No				
HBA1C	No	Select			No				
MICROALBUMIN	No	Select			No				
FOBT	Yes	Left Kit	33716033	33716033	Yes				
DEXA	N/A	Select			No				
PAD	No	Select			No				
LDL	No	Select			No				

## Mini-Cog

39. Mini- Cog (see attached sheet)



house?		
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?**

" more exercise, COVID has limited activity"

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

" I'm doing everything I think I can"

**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 :

after confirmation of patient's name and DOB a face to face appointment was performed. Patient was appropriate and answered questions correctly. A fecal occult kit was left and explained to the patient. All questions were answered.

### 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 :	2021-07-18T14:00
Time exam finished	2021-07-18T14:48
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Preventative Care checklist reviewed and left with member	<input type="checkbox"/>
Provider Signature	<div>  <div> Digitally signed by Lindsay Otis, NP 2021-07-18, 14:55 </div> </div>

Addendum	
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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?