

HRA Form

Health Plan :	Optima Health
Member Name :	JESSE L LANKFORD
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1954-04-15
Evaluation Date :	2021-7-10 09:00 AM
Visit Type :	

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	JESSE L LANKFORD
Gender	Male
Address	1801 ST DENIS AVE APT 2
City	NORFOLK
State	VA
Zip	23509-9998
Date of Birth	1954-04-15
Age(as of date)	67
Marital Status	Married
Member Identification Number	900046137*01
HICN	
Phone Number	757/773-4068
Cell Number	757/773-4068, 757/816-5759
Alternate Contact Number	757/773-4068, 757/816-5759,
Email	
Emergency Contact	CATHERINE LANKFORD / WIFE
Phone Number	757-773-4068
Primary Care Physician	JENNIFER POTTS
Phone Number	
PCP Address	7401 Granby St
PCP City	Norfolk
PCP State	VA

PCP Zip	23505
PCP County	
Office ID	
Office Name	Sentara Internal Medicine Phys

1. Race

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

Patient's Ethnicity

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

2. Preferred language

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

Previously Documented Conditions

Covid Screening

In the last 14 days, have you:

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

Self-Assessment and Social History

3. How much school have you completed?

- | | | |
|---|--|--|
| <input type="checkbox"/> Less than 3rd grade | <input type="checkbox"/> Completed 3rd grade | <input type="checkbox"/> Completed 8th grade |
| <input checked="" type="checkbox"/> Completed 12th grade | <input type="checkbox"/> Attended College | |

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

- ☐ Very difficult ☐ Somewhat difficult ☒ **Easy**
☐ Very easy to understand

comments

FORGET IT DUE TO DEMENTIA AT TIMES

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**
↳ **Describe**
DUPLEX

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

APPROX 49 YEARS

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

comments

EDUATION PROVIDED TO DISCUSS WITH PCP

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

Comment:

USES SIDERAILS

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

21. Are you currently seeing any specialists?

☒ Yes

☐ No

Medical Specialty	Specialist	For
Oncologist	ONCOLOGY	BLADDER CANCER
Dermatologist	DERM	urticaria
Neurologist	NEUROLOGIST	WILL SEE FOR DEMENTIA

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

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

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

☐ Yes

☒ No

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

Physical Therapist	Yes	No
Occupational Therapist	Yes	No
Dietician	Yes	No
Social Worker	Yes	No
Pharmacist	Yes	No
Speech Therapist	Yes	No
Chiropractor	Yes	No
Personal Care Worker (HHA, CNA, PCA)	Yes	No
Meals on Wheels	Yes	No

25. In the past two years have you received any of the treatments below?

Chemotherapy	Yes	No	Unknown
--------------	-----	----	---------

Comment: 2015 BLADDER CANCER

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
Father	NONE	GUNSHOT INJURY
Mother	HTN	HTN PER MEMBER

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	Yes
Breast Exam/Mammography	Not Applicable
Cervical Screening	Not Applicable
Bone Density	Not Applicable
Prostate Exam/PSA	Yes
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

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

comments EDUCATED TO DISCUSS WITH PCP AND BENEFITS

34. Have you been vaccinated for Herpes Zoster?

☐ Yes ☒ No

comments EDUCATED TO DISCUSS WITH PCP AND BENEFITS

Allergies / Medications

35. Allergies

☐ Yes ☒ No

comments PORK

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
	PANOXYL WASH	LIQ 0.1	Select	Select		Taking	Not Taking
	ATORVASTATIN	TAB 20MG	PO = By Mouth	Select	PCP	Taking	Not Taking
	LOSARTAN POT	TAB 50MG	PO = By Mouth	Select	PCP	Taking	Not Taking
	AMITIZA	CAP 24MCG	Select	Select	PCP	Taking	Not Taking
	BENZOYL PER	LIQ 10% WASH	Select	Select	PCP	Taking	Not Taking
	PREDNISON E	TAB 20MG	Select	Select	PCP	Taking	Not Taking
BRONCHITIS	ANORO	62.5/25MG	PO = By Mouth	AC	PCP	Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
07-09-2021	BISACODYL	5 MG	PO = By Mouth	1 PO DAILY

37. Chronic Use of

☒ None

comments SUPPOSE TO BE ON STATIN, AND NOT TAKING MEDS

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?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
3. Do you know the longterm benefit of taking your medicine as told to you by the doctor or pharmacist?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
4. When you feel better do you sometimes stop taking your medicine?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
5. Sometimes if you feel worse when you take your medicine do you stop taking it?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
6. Do you sometimes forget to refill your prescription on time?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No

Review of Systems and Diagnoses

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

☐ Yes ☒ No

Do you wear glasses or contacts?

☒ Yes ☐ No

Do you have trouble seeing even with glasses?

☐ Yes ☒ No

Do you have problems seeing at night?

☐ Yes ☒ No

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

☐ Yes ☒ No

Nose Problems (Nose Bleeds, Sinus infections, Other)

☐ Yes ☒ No

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

☐ Yes ☒ No

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes ☒ No

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

☒ Yes ☐ No

Diagnoses

- | | |
|--|--|
| <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 type="checkbox"/> Sleep Apnea |

- ☒ **Other**
- Other
- Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☐ History

☒ **Medications**

☐ Biopsy

☐ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

Other

comments

CHRONIC BRONCHITIS

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

- ☐ Abnormal Cardiac Rhythm

☐ Angina

☐ Cardio – Respiratory Failure / Shock

☐ Congestive Heart Failure

☒ **Hyperlipidemia**

☐ Ischemic Heart Disease (CAD)

☐ Peripheral Vascular Disease

☐ Valvular Disease

☐ Aneurysm

☐ Atrial Fibrillation

☐ Cardiomyopathy

☐ Deep Vein Thrombosis

☒ **Hypertension**

☐ Myocardial Infarction

☐ Pulmonary Hypertension

☐ Other

Hyperlipidemia

- Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☐ Lab results

☒ **Medication**

☐ Other

Is patient on Statin

☒ **Yes**

☐ **No**

comments

NON-COMPLIANT AND NEED PCP VISIT FOR EDUCATION AND ADHERENCE - NOT TAKING RX MEDS FOR LAST 7 MONTHS

Hypertension

- Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☐ Physical Exam

☒ **Medications**

☐ Symptoms

Other

Adequately controlled

Yes

No

UnKnown

comments

NON-COMPLIANT AND NEED PCP VISIT FOR EDUCATION AND ADHERENCE - NOT TAKING RX MEDS FOR LAST 7 MONTHS

History of Chest Pain

Yes

No

History of Intermittent Claudication

Yes

No

Implanted Pacemaker

Yes

No

Implanted Defibrillator

Yes

No

Do you have abnormal heart beats?

Yes

No

Does your heart race?

Yes

No

Do you sleep on more then one pillow?

Yes

No

have you ever have fluid in your lungs?

Yes

No

Do your legs or ankles swell up?

Yes

No

Do you follow a special diet?

Yes

No

Do you have headaches?

Yes

No

Do you feel light headed when you stand up?

Yes

No

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

Yes

No

Diagnoses

Bowel Obstruction

Cachexia

Celiac Disease

Cirrhosis

Colon Polyps

Diverticulitis

Gall Bladder Disease

Gastroparesis

GERD

Hepatitis

Inflammatory Bowel Disease

Pancreatitis

Ulcer Disease

Other

Inflammatory Bowel Disease

Describe

Active

History of

Rule out

Supported by

Colonoscopy

Symptoms

Physical Findings

Medications

Other

Other

Describe

comments

PATIENT SAY NO ISSUES RIGHT NOW AND NOT TAKING ANY MEDS

- Describe

Ulcerative Colitis

Crohn's Disease

☒ Other

comments

MEMBER WAS NOT ABLE TO SPECIFY

- On a specific diet

Yes

No

- Other

Describe

Active

History of

Rule out

comments

CONSTIPATION

- Supported by

History

Medications

Biopsy

Symptoms

Test results

DME

Physical Findings

Image studies

Other

- Other

comments

OTC MED AS ABOVE

History of blood in stool

- Yes

No

History of black stools

- Yes

No

History of Heartburn / Dyspepsia

- Yes

No

History of Vomiting or Regurgitation

- Yes

No

History of pain after eating

- Yes

No

History of Jaundice

- Yes

No

Do you follow a special diet?

- Yes

No

Do you have frequent abnormal abdominal pain?

- Yes

No

Do you have intermittent nausea or vomiting?

- Yes

No

Do you have trouble with constipation?

- ☒ Yes

No

Does diarrhea limit your ability to get out of the room or socially?

- Yes

No

Do you see blood in your urine?

- Yes

No

Do you have Frequent Stomach Pain

- Yes

No

Bowel Movements

- ☒ Normal

Abnormal

Abdominal Openings

☐ Yes

☒ No

Rectal Problems

☐ Yes

☒ No

Last Bowel Movement

☐ Today

☐ 1-3 days ago

☒ >3 days ago

comments

BOWEL MOVEMENT EVERY 2-3 DAYS

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

☒ Yes

☐ No

Diagnoses

- ☐ Alcohol Dependence

☐ Bipolar Disorder

☐ Cerebral Palsy

☒ Dementia

☐ Drug Dependence

☐ Generalized Anxiety Disorder

☐ Hemiparesis

☐ Insomnia

☐ Migraine Headaches

☐ Muscular Dystrophy

☐ Parkinson's disease

☐ Restless leg syndrome

☐ Seizure Disorder

☐ Stroke

☐ TIA

☐ Other
- ☐ Amyotrophic Lateral Sclerosis

☐ Cerebral Hemorrhage

☐ Delusional Disease

☐ Depression

☐ Fibromyalgia

☐ Guillain-Barre Disease

☐ Huntington's Chorea

☐ Intellectual and or Developmental Disability

☐ Multiple Sclerosis

☐ Myasthenia Gravis

☐ Peripheral Neuropathy

☐ Schizophrenia

☐ Spinal Cord Injury

☐ Subdural Hematoma

☐ Traumatic Brain Injury

Dementia

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Behavioral changes

☐ Functional changes

☐ Mental testing

☐ Other

☐ MRI

comments

PER WIFE, HE HAS BEEN FORGETTING NORMAL THINGS OR SHORT TERM MEMORY. HAS UPCOMING NEUROLOGIST APPT

Type of Dementia

☒ Vascular

☐ Alzheimer's disease

☐ Etiology Unknown

Supported by

☒ History of strokes

☐ Risk factors (Atrial Fibrillation, Diabetes, Hypertension, Hypercholesterolemia, Smoking)

comments

PER MEMBER HAD STROKE WITHOUT MOTOR OR NEUROLOGIC DEFICIT

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

- | | |
|--|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you worry too much about different things? | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you feel afraid that something bad might happen? | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| History of headaches | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| History of auditory hallucinations | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| History of visual hallucinations | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| History of psychotic behavior | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| History of episodes of delirium | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you follow a special diet? | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> 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? | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you have trouble swallowing your food? | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you have trouble making people understand you when you speak? | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you trouble understanding what people say to you? | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do your hands shake? | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you have convulsions and seizures? | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you have trouble with your memory? | |
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have trouble finding words? | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you have trouble sleeping? | |
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| comments | AT TIMES DO NOT SLEEP DUE TO URTICARIA AND BPH |
| Have you lost your appetite | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you hear voices or see things that other people do not | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you have highs and lows | |
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you ever feel like someone is out to get you | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| How often do you go out to meet with family or friends | |

☐ Often
 ☐ Sometimes
 ☒ **Never**

comments

MY KIDS COME AND SEE ME BUT I DO NOT GO OUT

GPCOG Score or MMSE Score

GPCOG Score	or MMSE Score

If GPCOG or MMSE is not done, is

- ☒ **Yes**
☐ No
- ☒ **Yes**
☐ No
- ☒ **Yes**
☐ No
- ☒ **Good**
☐ Poor
- ☒ **Yes**
☐ Partially
 ☐ No

Affect

☒ **Normal**
☐ Abnormal

comments

SPEAKS CLEARLY

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
- ☐ Intention Tremor
- ☐ Spasticity
- ☒ **Normal**
- ☐ Vocal Tic
- ☐ Non-Intention (Pill rolling) Tremor
- ☐ Chorea Movement
- ☐ Benign (Essential Tremor)
- ☐ Rigidity
- ☐ Cog wheeling

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

Diagnoses

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

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

- ☐ Physical exam
- ☐ Biopsy
- ☐ Other
- ☒ **Symptoms**
- ☐ Medication
- ☐ Lab test
- ☐ Hospitalization

comments

UNTREATED

History of frequency

☐ Yes

☒ **No**

History of Nocturia

☒ **Yes**

☐ No

- ☐ 1x / night
- ☒ **2x / night**
- ☐ 3x / night
- ☐ >=4x / night

History of Hesitancy

☐ Yes

☒ **No**

Do you have trouble urinating?

☐ Yes

☒ **No**

Do you ever have blood in your urine?

☐ Yes

☒ **No**

Do you have any weakness or deformity in your arms or legs that limits your ability to get

around or do what you want to do?

☐ Yes ☒ No

Do you have trouble holding your urine?

☒ Yes ☐ No

comments

AT TIMES

Do you trouble getting to the bathroom on time?

☐ Yes ☒ No

Do you ever have pain or burning during urination?

☐ Yes ☒ No

Do you ever wear pads or diapers?

☐ Yes ☒ No

Do you have a vaginal discharge?

☐ Yes ☒ No

Do you have vaginal bleeding?

☐ Yes ☒ No

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

☐ Yes ☒ No

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

☒ Yes ☐ No

↳ Diagnoses

☐ Basil Cell Carcinoma

☐ Eczema

☐ Skin ulcer

☐ Wound

☐ Urticarial Disease

↳ Describe

☒ Active

↳ Supported by

☐ History

☐ Medications

☐ Biopsy

↳ Type

☐ Acute

↳ Etiology

☐ Dermatitis

☐ Psoriasis

☒ Urticarial Disease

☐ Other

☐ History of

☒ Symptoms

☐ Test results

☐ DME

☒ Chronic

☐ Rule out

☐ Physical Findings

☐ Image studies

☐ Other

comments

UNKNOWN - MEMBER SAYS, NOTHING IS WORKING

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

Diagnoses

- | | |
|---|--|
| <input type="checkbox"/> AIDS | <input checked="" type="checkbox"/> Anemia |
| <input type="checkbox"/> C. Difficile | <input type="checkbox"/> Community Acquired MRSA Infection |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Herpes Zoster |
| <input type="checkbox"/> Hospital Acquired MRSA Infection | <input type="checkbox"/> Immune Deficiency |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Multiple Myeloma | <input type="checkbox"/> Sepsis |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Sickle Cell Trait |
| <input type="checkbox"/> Thalassemia | <input type="checkbox"/> Thrombocytopenia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Vitamin D Deficiency |
| <input type="checkbox"/> Other | |

Anemia

Describe

☐ Active

☒ **History of**

☐ Rule out

Supported by

☒ **Lab tests**

☐ Symptoms

☐ History of blood transfusion

☐ Other

Etiology

☐ Iron deficiency

☐ Pernicious

☐ Kidney disease

☐ Hemolysis

☐ Aplastic

☐ Chemotherapy

☐ Blood loss

☐ Chronic Disease

☐ Folate Deficiency

☒ **Other**

Other

Describe

comments

UNKNOWN

If yes, Patient on

☐ Iron

☐ B 12

☐ Folic Acid

☐ Blood Transfusions ☒ **Other**

Other

Describe

comments

NO SUPPLEMENT

Easy bruising or abnormal bleeding

☐ Yes ☒ **No**

Long term anticoagulation use

☐ 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

comments

HAD CHEMOTHERAPY IN 2015

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

BLADDER CANCER

Stage or Classification specific to the cancer

UNKNOWN S/P CHEMOTHERAPY

Active treatment

☐ Yes

☒ No

History / Finding of Metastasis

☐ Yes

☒ No

Do you see a specialist?

☒ Yes

☐ No

Provider

ONCOLOGIST

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)	18			0/10

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	9 (Inch)	166 (lbs)	24.5

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

Head and Face

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

Comment: VIRTUAL EXAM

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
Examination of oropharynx:	Normal	Abnormal

Comment: VIRTUAL EXAM

Neck

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

Comment: VIRTUAL EXAM

Pulmonary

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

Percussion of chest:	Normal	Abnormal
Palpation of chest:	Normal	Abnormal
Auscultation of lungs:	Normal	Abnormal
Comment: VIRTUAL EXAM		

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: VIRTUAL EXAM		

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
Comment: ARMS WITH DRY SKIN & SCRATCH MARK FROM ITCHING		
Palpation of skin and subcutaneous tissue:	Normal	Abnormal
Comment: VIRTUAL EXAM		

Neurologic

Indicate specific cranial nerve tested

CN II THRU VII EXCEPT CN X & XI

Indicate cranial nerve deficits found

NONE

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

Diabetes

Foot Exam:	Normal	Abnormal
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Psychiatric

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

Comment: NEWLY DIAGNOSIS OF DEMENTIA

Mood and affect:	Normal	Abnormal
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Screenings Needed

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

Mini-Cog

39. Mini- Cog (see attached sheet)

Step 1: Three Word Registration

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

The following and other word lists have been used in one or more clinical studies.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: RIVER & NATION

Word Recall :	2 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 :	4 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?

I CAN'T THINK OF ANYTHING ELSE

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

MAY BE DO MORE THINGS - PHYSICAL ACTIVITIES

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 IDENTIFIED BY DOB/ADDRESS/INS CARD. PREVENTIVE EDUCATION COMPLETED AND ASK TO FOLLOW UP WITH PCP. MEMBER AND WIFE UNHAPPY WITH CURRENT CONTINUATION CARE AND MAY BENEFIT FROM A CASE MANAGER. NON-ADHERING TO MED MANAGEMENT AND NEED TO FOLLOW UP WITH PCP. MEMBER DO NOT APPRECIATE MANY DIAGNOSIS AND WILL BENEFIT FROM CASE MANAGER OR CARE MANAGER. PREVENTIVE CARE AND VACCINATION DISCUSSED.

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 :	2021-07-10T09:10
Time exam finished	2021-07-10T10:43
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input checked="" type="checkbox"/>
Preventative Care checklist reviewed and left with member	<input type="checkbox"/>
Provider Signature	<div> <div>Tejas Vaishnav - TV</div> <div>  <div>Digitally signed by Tejas Vaishnav, NP 2021-07-12, 22:44</div> </div> </div>
Addendum	

Disclosure Statement

Your health plan, has contracted with Focus Care to conduct a health exam on all of its Medicare members, including you. The health exam includes questions to help your health plan learn more about your current health. The exam may also find things that could effect your health. The results of the exam will help your health plan and your doctor keep you as healthy as possible.

Personal health information, or PHI, is information in your medical record that identifies the record as your record. PHI includes things like your date of birth, age, address, telephone number, and your medical history.

Most of the time, Focus Care will not release your personal information without your permission. Measures are in place to prevent your personal information from being accidentally released in writing, including by use of a computer, or orally. You may request more information about how your personal information is protected.

There are times when Focus Care is allowed to release your personal information without your permission. For example, your medical information may be given to other health care providers who take care of you. The results of this exam will be sent to your health plan and to your doctor.

Focus Care may release your personal health information to a 'business associate'. A 'business associate' is another agency that Focus Care uses to do things, such as billing. We require our 'business associates' to have security measures in place to prevent your personal information from being accidentally released in writing, including by use of a computer, or orally.

Focus Care may be required to release your personal health information, without your permission, by law. including statutes, regulations, or valid court orders.

Focus Care will obtain your permission to use or release your personal health information for any other reason.

Do you have any questions about this information? Would you like to receive this information in a different language?

Your agreement to have this medical exam means you have given your permission to Focus Care to release the results of your medical exam to your health plan and to your doctor. Do you agree?