

HRA Form

Health Plan :	Optima Health
Member Name :	MICHELLE C BEARTH
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1971-03-28
Evaluation Date :	2021-7-28 11:00 AM
Visit Type :	

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	MICHELLE C BEARTH
Gender	Female
Address	6417 ROSE HILL DR C/O DANIEL BEARTH
City	ALEXANDRIA
State	VA
Zip	22310-9998
Date of Birth	1971-03-28
Age(as of date)	50
Marital Status	Single
Member Identification Number	900046579*01
HICN	
Phone Number	703/971-4357
Cell Number	703/971-4357,
Alternate Contact Number	703/971-4357,
Email	
Emergency Contact	
Phone Number	
Primary Care Physician	DUMLAO-UMAYAM, JANUARY MD
Phone Number	703/797-6970
PCP Address	6355 WALKER LANE SUITE 500
PCP City	ALEXANDRIA
PCP State	VA

PCP Zip	22310
PCP County	
Office ID	199476
Office Name	

### 1. Race

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

### Patient's Ethnicity

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

### 2. Preferred language

- ☒ **English**
☐ Other

## Previously Documented Conditions

## Covid Screening

In the last 14 days, have you:

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

## Self-Assessment and Social History

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

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

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

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

5. When you read the instructions on a prescription bottle would you say that it is

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

6. How confident are you in filling out medical forms by yourself?

- ☒ **Not at All Confident** ☐ Not Very Confident ☐ Confident  
☐ Very Confident

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

- ☐ Excellent ☒ **Good** ☐ Fair  
☐ Poor

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

- ☒ **Often** ☐ Sometimes ☐ Almost Never  
☐ Never

9. Where do you currently live?

- ☒ **Home** ☐ Apartment ☐ Assisted Living  
☐ Nursing Home ☐ Homeless ☐ Other

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

- ☒ **Yes** ☐ No

11. Who do you currently live with?

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

12. Are you currently a caregiver for someone?

- ☐ Yes ☒ **No**

13. Tobacco use

- ☐ Current ☐ Former ☒ **Never**

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

### Name

Ingrid Bearth  
Daniel Bearth

### Relationship

mom and step-dad

## 18. Do you have an Advance Directive?

☒ Yes ☐ No ☐ Don't Know

### Where is it kept?

at the home. has a special needs trust

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

### 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
----------------------------	----	----------------	-----------------

### 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

- |   |  |                                     |
|---|--|-------------------------------------|
| <input type="checkbox"/> Cane                   | <input type="checkbox"/> Walker          | <input type="checkbox"/> Prosthesis |
| <input checked="" type="checkbox"/> Wheel Chair | <input type="checkbox"/> Bedside Commode | <input type="checkbox"/> Urinal     |
| <input type="checkbox"/> Bed Pan                | <input type="checkbox"/> Other           |                                     |

comments

sleep safe bed, shower chair

## 21. Are you currently seeing any specialists?

- ☒ Yes ☐ No

Medical Specialty	Specialist	For
Ophthalmologist	Dr. Shah	glaucoma

## 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

Describe  
hypothermia

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

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

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

Chemotherapy	Yes	No	Unknown
Catheter Care	Yes	No	Unknown

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

Family History

26. Family History

☒ Yes

☐ No

Family Member	Medical Condition	Cause of Death
Mother	breast cancer	

Preventive Care

27. In the past three years have you had?

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

### Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
GLAUCOMA	DorzolamidT imolole	2%/0.5%	E = Eye	BID	DR. SHAH	Taking	Not Taking

### 36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
07-28-2021	MVI		PO = By Mouth	QD

### 37. Chronic Use of

☒ None

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

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

## Review of Systems and Diagnoses

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

☒ Yes ☐ No

#### Diagnoses

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

#### Glaucoma

##### Describe

☒ **Active** ☐ History of ☐ Rule out

##### Supported by

<input checked="" type="checkbox"/> <b>History</b>	<input type="checkbox"/> Symptoms	<input type="checkbox"/> Physical Findings
<input checked="" type="checkbox"/> <b>Medications</b>	<input type="checkbox"/> Test results	<input type="checkbox"/> Image studies
<input type="checkbox"/> Biopsy	<input type="checkbox"/> DME	<input type="checkbox"/> Other

comments

Dorzolamide/Timolol drops

##### Secondary to Diabetes

☐ Yes ☒ **No**

#### Others

##### Describe

☒ **Active** ☐ History of ☐ Rule out

##### Supported by

<input checked="" type="checkbox"/> <b>History</b>	<input type="checkbox"/> Symptoms	<input checked="" type="checkbox"/> <b>Physical Findings</b>
<input type="checkbox"/> Medications	<input type="checkbox"/> Test results	<input type="checkbox"/> Image studies
<input type="checkbox"/> Biopsy	<input type="checkbox"/> DME	<input type="checkbox"/> Other

##### Other

comments

Patient has a right prosthetic eye. Parents state pt can become aggressive and will bang her head against the wall and states this caused an eye injury that caused her to lose her eye.

### 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

### Difficulty Swallowing

#### ↳ Describe

☒ **Active**

☐ History of

☐ Rule out

#### ↳ Have you had a stroke

☐ Yes

☒ **No**

## Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes

☒ **No**

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

☐ Yes

☒ **No**

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

☐ Yes

☒ **No**

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

☐ Yes

☒ **No**

## Bowel Movements

☐ Normal

☒ **Abnormal**

### ↳ If abnormal

☐ Constipation

☐ Diarrhea

☒ **Bowel Incontinence**

## Abdominal Openings

☐ Yes

☒ **No**

## Rectal Problems

☐ Yes

☒ **No**

## Last Bowel Movement

☒ **Today**

☐ 1-3 days ago

☐ >3 days ago

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

☒ Yes

☐ No

### ↳ Diagnoses

☐ Alcohol Dependence

☐ Amyotrophic Lateral Sclerosis

☐ Bipolar Disorder

☐ Cerebral Hemorrhage

☐ Cerebral Palsy

☐ Delusional Disease

☐ Dementia

☐ Depression

☐ Drug Dependence

☐ Fibromyalgia

- ☐ Generalized Anxiety Disorder

☐ Hemiparesis

☐ Insomnia

☐ Migraine Headaches

☐ Muscular Dystrophy

☐ Parkinson's disease

☒ Restless leg syndrome

☒ Seizure Disorder

☐ Stroke

☐ TIA

☐ Other
- ☐ 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

Intellectual and or Developmental Disability

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ History☐ Medications☐ Biopsy

☒ Symptoms☐ Test results☐ DME

☒ Physical Findings☒ Image studies☐ Other

comments

Pt is nonverbal, dependent for all ADLs. Pt can become physically aggressive, bang her head against the wall, and hit her parents. Pt does not like to be touched and will withdraw from physical contact

Describe

- ☐ Down's Syndrome
- ☐ Psychomotor Retardation
- ☐ Other

comments

Mom and step-dad report pt was diagnosed with Autism when pt was 18 months old

Restless leg syndrome

Describe

- ☒ Active
- ☐ History Of
- ☐ Rule out

Supported by

- ☒ Symptoms
- ☐ Medication
- ☐ History
- ☐ Other

comments

mom states pt's legs jerk during the night, right leg is worse than the left. Pt has difficulty resting due to leg movements

Seizure Disorder

Describe

- ☐ Active
- ☒ History of
- ☐ Rule out

Supported by

- ☒ History of recurrent seizures
- ☒ Medications
- ☐ Laboratory testing
- ☐ Other

comments

was on medications a few years ago but these have been stopped. has not had any recent seizures

Traumatic Brain Injury

Describe

- ☐ Active
- ☒ History of
- ☐ Rule out

Supported by

- ☒ Hospitalization
- ☒ Image studies
- ☐ Physical findings

☐ Other

comments

mom reports pt was physically abused by her father when she was a baby. patient was hit and thrown against the wall, left alone for days with a fever before being found and send to the hospital. dad is no longer in pt's life.

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

☐ Yes

☒ No

Do you worry too much about different things?

☐ Yes

☒ No

Do you feel afraid that something bad might happen?

☐ Yes

☒ No

History of headaches

☐ Yes

☒ No

History of auditory hallucinations

☐ Yes

☒ No

History of visual hallucinations

☐ Yes

☒ No

History of psychotic behavior

☐ Yes

☒ No

History of episodes of delirium

☐ Yes

☒ No

Do you follow a special diet?

☐ Yes

☒ No

Do you have any weakness or deformity in your arms or legs that limits your ability to get around or do what you want to do?

☒ Yes

☐ No

Do you have trouble swallowing your food?

☒ Yes

☐ No

comments

eats a soft diet.

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

☒ Yes

☐ No

Do you trouble understanding what people say to you?

☒ Yes

☐ No

Do your hands shake?

☐ Yes

☒ No

Do you have convulsions and seizures?

☐ Yes

☒ No

Do you have trouble with your memory?

☐ Yes

☒ No

Do you have trouble finding words?

☒ Yes

☐ No

Do you have trouble sleeping?

☒ Yes

☐ No

Have you lost your appetite

☐ Yes

☒ No

Do you hear voices or see things that other people do not

☐ Yes

☒ No

Do you have highs and lows

☐ Yes

☒ No

Do you ever feel like someone is out to get you

☐ Yes ☒ No

How often do you go out to meet with family or friends

☒ Often ☐ Sometimes ☐ Never

GPCOG Score or MMSE Score

GPCOG Score	or MMSE Score

If GPCOG or MMSE is not done, is

↳ Patient oriented to person

☒ Yes ☐ No

↳ Patient oriented to place

☒ Yes ☐ No

↳ Patient oriented to time

☐ Yes ☒ No

↳ Recall

☐ Good ☒ Poor

↳ Patient describes recent news event

☐ Yes ☐ Partially ☒ No

Affect

☐ Normal ☒ Abnormal

↳ If abnormal,

☐ Paranoia

☐ Delusional

☒ Disorganized thought

☐ Flat

☐ Manic

☐ Depressed

☐ Other

comments

non-verbal, unable to comprehend instructions

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	Not at all	Several Days	More than half the days	Nearly every day
Feeling down, depressed or hopeless	Not at all	Several Days	More than half the days	Nearly every day

comments

difficult to assess due to pt being nonverbal. mom states pt seems generally happy

PHQ 2 Score

☒ < 3 ☐ 3 or more

Speech

☐ Normal

☐ Slurred

☒ Aphasic

☐ Apraxia

comments

Pt exhibits signs of Apraxia also

Finger to Nose

- ☐ Normal
- ☐ Abnormal

comments

virtual visit

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

Facial / Extremity Movement

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

comments

spasticity of BUE's

Gait

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

comments

non ambulatory. uses a wheelchair for ambulation

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

- ☒ Yes
- ☐ No

Diagnoses

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

Urinary Incontinence

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- |  |   |  |
|--|---|--|
| <input checked="" type="checkbox"/> <b>History</b> | <input checked="" type="checkbox"/> <b>Symptoms</b> | <input type="checkbox"/> Physical Findings     |
| <input type="checkbox"/> Medications               | <input type="checkbox"/> Test results               | <input type="checkbox"/> Image studies         |
| <input type="checkbox"/> Biopsy                    | <input type="checkbox"/> DME                        | <input type="checkbox"/> Other                 |
| <input type="checkbox"/> Related to stress         |   |  |
| <input type="checkbox"/> Yes                       | <input checked="" type="checkbox"/> <b>No</b>       |  |
| <input type="checkbox"/> Describe                  | <input type="checkbox"/> Few times a week           | <input type="checkbox"/> Less than once a week |
| <input checked="" type="checkbox"/> <b>Daily</b>   |   |  |

#### History of frequency

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> No                         |
| <input type="checkbox"/> 3x / day              | <input type="checkbox"/> 4x / day                   |
| <input type="checkbox"/> >5x / day             | <input checked="" type="checkbox"/> <b>5x / day</b> |

#### History of Nocturia

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> No                           |
| <input type="checkbox"/> 1x / night            | <input type="checkbox"/> 2x / night                   |
| <input type="checkbox"/> >=4x / night          | <input checked="" type="checkbox"/> <b>3x / night</b> |

#### History of Hesitancy

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

#### Do you have trouble urinating?

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

#### Do you ever have blood in your urine?

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

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

#### Do you have trouble holding your urine?

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

#### Do you trouble getting to the bathroom on time?

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

#### Do you ever have pain or burning during urination?

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

#### Do you ever wear pads or diapers?

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

#### Do you have a vaginal discharge?

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

#### Do you have vaginal bleeding?

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

comments

still has her menses

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

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

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

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

## 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
---------------------	-----	----

## Pain

### Does the patient experience pain?

☐ Yes ☒ No

## Vital Signs

### Vital Signs

comments

virtual visit

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
(mmHG)	(mmHG)	(bpm)				

## BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	(Inch)	150 (lbs)	29.3

☐ 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 visit

## Eyes

Inspection of conjunctiva and lids:	Normal	Abnormal
Examination of pupils and irises:	Normal	Abnormal

Comment: right eye prosthesis

## Ears, Nose, Mouth and Throat

External Inspection of ears and nose:	Normal	Abnormal
Otoscopic examination:	Normal	Abnormal

Comment: virtual visit

Assessment of hearing:	Normal	Abnormal
Inspection of nasal mucosa, septum and turbinates:	Normal	Abnormal
Inspection of lips, teeth and gums:	Normal	Abnormal
Examination of oropharynx:	Normal	Abnormal

Comment: virtual visit

## Neck

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

Comment: virtual visit

## Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
Percussion of chest:	Normal	Abnormal

Comment: virtual visit

Palpation of chest:	Normal	Abnormal
---------------------	--------	----------

Comment: virtual visit

Auscultation of lungs:	Normal	Abnormal
------------------------	--------	----------

Comment: virtual visit

## Cardiovascular

Palpation of heart:	Normal	Abnormal
---------------------	--------	----------



Comment: virtual visit

Auscultation of heart:	Normal	Abnormal
------------------------	--------	----------

Comment: virtual visit

Carotid Arteries:	Normal	Abnormal
-------------------	--------	----------

Comment: virtual visit

Abdominal Aorta:	Normal	Abnormal
------------------	--------	----------

Comment: virtual visit

Pedal Pulses:	Normal	Abnormal
---------------	--------	----------

Comment: virtual visit

Examination of Arterial Pulses:	Normal	Abnormal
---------------------------------	--------	----------

Comment: virtual visit

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

## Lymphatic

Palpation of cervical nodes (neck)	Normal	Abnormal
------------------------------------	--------	----------

Comment: virtual visit

Palpation of preauricular nodes (in front of the ears)	Normal	Abnormal
--	--------	----------

Comment: virtual visit

Palpation of Submandibular nodes (under jaw line/chin)	Normal	Abnormal
--	--------	----------

Comment: virtual visit

## Musculoskeletal

Examination of gait and station:	Normal	Abnormal
----------------------------------	--------	----------

Comment: use of wheelchair for mobility

Inspection/palpation of digits and nails:	Normal	Abnormal
---	--------	----------

Inspection/palpation of joints, bones and muscles:	Normal	Abnormal
--	--------	----------

Comment: virtual visit

Assessment of range of motion:	Normal	Abnormal
--------------------------------	--------	----------

Comment: contractures of BUEs

Assessment of stability:	Normal	Abnormal
--------------------------	--------	----------

Comment: balance impairment

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

Comment: generalized weakness, impaired balance, inability to ambulate

## Skin

Inspection of skin and subcutaneous tissue:	Normal	Abnormal
Palpation of skin and subcutaneous tissue:	Normal	Abnormal
Comment: virtual visit		

## Neurologic

Indicate specific cranial nerve tested

none- Patient did not understand instructions

Indicate cranial nerve deficits found

UTD

Romberg Test	Normal	Abnormal
Comment: patient unable to stand alone		
Examination of reflexes:	Normal	Abnormal
Comment: virtual visit		
Examination of sensation:	Normal	Abnormal
Comment: virtual visit		
Coordination:	Normal	Abnormal
Comment: loss of balance		

## Diabetes

Foot Exam:	Normal	Abnormal
------------	--------	----------

## Psychiatric

Description of patient's judgement / insight:	Normal	Abnormal
Comment: difficult to assess due to patient being nonverbal		
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			Select				

HBA1C	No	Select			Select				
MICROALBUMIN	No	Select			Select				
FOBT	Yes	Select			Select				
DEXA	N/A	Select			Select				
PAD	No	Select			Select				
LDL	No	Select			Select				

## Mini-Cog

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

comments

Patient not able to perform exam

#### 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 : 3

Person's Answers: **table, baby, chair**

Word Recall :	0 Points	1 point for each word spontaneously recalled without cueing. Home Safety Yes
Clock Draw :	0 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 :	0 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?  
none

43. Is there anything that you could do to improve your quality of life?  
parents have asked PCP for a referral for Physical and Occupational therapy evaluations.

44. Have you ever physically or felt emotionally abused by someone  
☒ Yes ☐ No

comments

Patient was physically abused by her dad when she was a baby. Pt was hit, left alone, and thrown against the wall

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 :

Virtual visit completed. Pt's identity confirmed with name, dob, address, and parents present. Pt is a 50 year old female that lives at home with her parents. Pt has had a TBI when she was a baby resulting in Intellectual disabilities. Pt's mom states pt was also diagnosed with Autism when pt was 18 months old. Pt is dependent for all ADLs. Pt was advised by PCP to have a colonoscopy, mammogram, and pap as pt has never had any of these. Step-dad reports pt was seen by GI and a blood test was done which was negative for colon cancer and they are not following up with him. Pt is easily agitated and does not like to be touched and they are reluctant to put pt through the mammogram and pap. Pt has

never been sexually active and still has her menses. Mom has breast cancer. Provider instructed mother that when they shower pt to feel for any abnormal lumps at that time. Mom also instructed to discuss with PCP if a breast Ultrasound could be scheduled as pt would probably tolerate this better. Mom instructed to keep appt with GYN to discuss if pt really needs a PAP. Pt has s/s of RLS and mom will call the doctor to enquire on medication for this. Parents verbalize understanding of all instructions. Provider to send a referral form to Focus Cares for PT/OT Eval

### 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 :	2021-07-28T11:05
Time exam finished	2021-07-28T11:50
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> Leslie Berryman, NP-C </div> <div>  </div> <div> Digitally signed by Leslie Berryman, FNP 2021-07-28, 12:46 </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?