

HRA Form

| | |
|-------------------|------------------------|
| Health Plan : | Optima Health |
| Member Name : | WILLIAM A WATKINS |
| Evaluator Name : | |
| Assessment Type : | Health Risk Assessment |
| DOB : | 1955-06-20 |
| Evaluation Date : | 2021-7-12 11:00 AM |
| Visit Type : | |

Demographics

| | |
|------------------------------|--------------------------------|
| Plan | OHP - OPTIMA |
| Program | MEDICARE |
| LOB | DSNP |
| Name | WILLIAM A WATKINS |
| Gender | Male |
| Address | 223 MCCONVILLE ROAD PO BOX 476 |
| City | LYNCHBURG |
| State | VA |
| Zip | 24502-9998 |
| Date of Birth | 1955-06-20 |
| Age(as of date) | 66 |
| Marital Status | Single |
| Member Identification Number | 900046825*01 |
| HICN | |
| Phone Number | 434/579-9925 |
| Cell Number | 434/579-9925, 434/579-9925 |
| Alternate Contact Number | 434/579-9925, 434/579-9925, |
| Email | |
| Emergency Contact | |
| Phone Number | |
| Primary Care Physician | CARMACK, JOHN MD |
| Phone Number | 434/534-6868 |
| PCP Address | 1088 LONDON LINKS RD |
| PCP City | FOREST |
| PCP State | VA |

| | |
|-------------|---------|
| PCP Zip | 24551 |
| PCP County | BEDFORD |
| Office ID | 45190 |
| Office Name | CVFP |

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
 ☐ Describe

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

quit 16 years ago was smoking 2 PPD at that time.

14. Alcohol Use

☐ Current
 ☐ Former
 ☒ **Never**

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

☐ Yes
 ☒ **No**

16. Do you have a Healthcare Proxy?

☒ **Yes**
☐ No
 ☐ Don't Know

↳ Name

Janie Conner

↳ Relationship

daughter

17. Do you have a Durable Power of Attorney?

☒ **Yes**
☐ No
 ☐ Don't Know

↳ Name

Janie Conner

↳ Relationship

daughter

18. Do you have an Advance Directive?

☒ **Yes**
☐ No
 ☐ Don't Know

↳ Where is it kept?

daughter has copy

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

Comments: only with walker

| | | | |
|----------------------------|----|----------------|-----------------|
| 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

Comments: able to climb easily, needs assistance going down stairs

Medical History

20. Do you use any assistive devices? (Check device or none if no devices used)

- ☐ None
 ☒ Cane
 ☒ Walker
 ☐ Prosthesis
 ☐ Wheel Chair
 ☐ Bedside Commode
 ☐ Urinal
 ☐ Bed Pan
 ☒ Other
- Describe shower chair

21. Are you currently seeing any specialists?

- ☒ Yes
 ☐ No

| Medical Specialty | Specialist | For |
|-------------------|--------------------------------|----------------------|
| Cardiologist | Centra Cardiology | CAD |
| Neurologist | Dr. Policard, Centra Neurology | stroke |
| Endocrinologist | Dr. Kaupy, Centra | Diabetes |
| Ophthalmologist | Piedmont eye center | diabetic retinopathy |
| Psychiatrist | Centra, Dr. Johnson | depression |

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

| | | | | | | |
|-------------------------------|------|---|---|---|---|-----------|
| A. Seen your PCP | None | 1 | 2 | 3 | 4 | 5 or more |
| B. Visited the Emergency Room | None | 1 | 2 | 3 | 4 | 5 or more |

If one or more, describe

Stroke
MI/ AKI

| | | | | | | |
|-------------------------------------|------|---|---|---|---|-----------|
| C. Stayed in the hospital overnight | None | 1 | 2 | 3 | 4 | 5 or more |
|-------------------------------------|------|---|---|---|---|-----------|

If one or more, describe

stroke
MI/AKI

elevated BGL

| | | | | | | |
|---------------------------|------|---|---|---|---|-----------|
| D. Been in a nursing home | None | 1 | 2 | 3 | 4 | 5 or more |
|---------------------------|------|---|---|---|---|-----------|

[If one or more, describe](#)

two stays each after hospital discharges

| | | | | | | |
|----------------|------|---|---|---|---|-----------|
| E. Had Surgery | None | 1 | 2 | 3 | 4 | 5 or more |
|----------------|------|---|---|---|---|-----------|

[If one or more, describe](#)

Stent placement
Loop recorder placement

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

☒ Yes

☐ No

[Describe](#)
CAD

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: three-four days a week

| | | |
|-----------------|-----|----|
| 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 |

Comment: had dialysis catheter placed and removed.

| | | | |
|--------------------|-----|----|---------|
| 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 | | lung cancer |
| Father | | MI |

Preventive Care

27. In the past three years have you had?

| Screen | Answer |
|----------------------------|----------------|
| Colonoscopy | Yes |
| Breast Exam/Mammography | No |
| Cervical Screening | Not Applicable |
| Bone Density | No |
| Prostate Exam/PSA | Don't Know |
| 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

↳ Pneumovax

☐ Yes ☐ No ☒ Unknown

↳ Prevenar

☐ Yes ☐ No ☒ Unknown

34. Have you been vaccinated for Herpes Zoster?

☒ Yes
☐ No

Zostervax

☐ Yes
☐ No

Shingrex

☐ Yes
☐ No

☒ Unknown
☒ Unknown

Allergies / Medications

35. Allergies

☒ Yes
☐ No

| Substance | Reaction |
|-------------|----------------------------|
| penicillian | unknown, reaction as child |

Medications

| Diagnoses | Label Name | Dose / Units | Route | Frequency | Prescribing Physician | Status | |
|-------------------------|------------------|--------------|-------------------|-----------|-----------------------|--------|------------|
| GERD | PANTOPRAZOLE TAB | 40MG | PO = By Mouth | QD | | Taking | Not Taking |
| hyperlipidemia | ATORVASTATIN TAB | 80MG | PO = By Mouth | QD | | Taking | Not Taking |
| diabetes | NOVOLOG | INJ FLEXPEN | SQ = Subcutaneous | TID | | Taking | Not Taking |
| diabetes | LEVEMIR | 30 AM, 40 PM | SQ = Subcutaneous | BID | | Taking | Not Taking |
| CHF | FUROSEMIDE | TAB 40MG | PO = By Mouth | BID | | Taking | Not Taking |
| hypocalcemia | CALCITRIOL | CAP 0.25MCG | PO = By Mouth | QD | | Taking | Not Taking |
| stroke/CAD | CLOPIDOGREL | TAB 75MG | PO = By Mouth | QD | | Taking | Not Taking |
| depression | MIRTAZAPINE | TAB 15MG | PO = By Mouth | QD | | Taking | Not Taking |
| BPH | TAMSULOSIN | CAP 0.4MG | PO = By Mouth | QD | | Taking | Not Taking |
| orthostatic hypotension | midodrine | 5 mg | PO = By Mouth | QD | | Taking | Not Taking |
| depression | Duloxetine | 60 mg | PO = By Mouth | BID | | Taking | Not Taking |
| vitamin deficiency | zinc | 50 mg | PO = By Mouth | QD | | Taking | Not Taking |
| vitamin deficiency | multi vit | 1 tab | PO = By Mouth | QD | | Taking | Not Taking |
| stroke/CAD | eliquis | 5mg | PO = By Mouth | BID | | Taking | Not Taking |

36. Over the Counter Medications / Supplements

☐ Yes ☒ No

37. Chronic Use of

☐ None

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

38. Medication Compliance and Knowledge of Use and Disease

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

Review of Systems and Diagnoses

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

☒ Yes ☐ No

Diagnoses

☐ Cataracts ☐ Difficulty with vision
☐ Glaucoma ☐ Hyperopia
☐ Macular Degeneration ☐ Myopia
☒ Retinal Disease ☐ Others

Retinal Disease

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☐ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Secondary to Diabetes

☒ Yes

☐ No

Vitreous Hemorrhage

☐ Yes

☒ No

Do you wear glasses or contacts?

☐ Yes

☒ No

Do you have problems seeing at night?

☐ Yes

☒ No

Do you have eye pain?

☐ Yes

☒ No

Do you have problems with tearing?

☐ Yes

☒ No

Do you have a problem with dry eye?

☐ Yes

☒ No

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

☐ Yes

☒ No

Nose Problems (Nose Bleeds, Sinus infections, Other)

☐ Yes

☒ No

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

☐ Yes

☒ No

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

Diagnoses

- ☐ Abnormal Cardiac Rhythm

☐ Aneurysm
- ☐ Angina

☐ Atrial Fibrillation
- ☐ Cardio – Respiratory Failure / Shock

☒ **Cardiomyopathy**
- ☒ **Congestive Heart Failure**

☐ Deep Vein Thrombosis
- ☒ **Hyperlipidemia**

☐ Hypertension
- ☒ **Ischemic Heart Disease (CAD)**

☒ **Myocardial Infarction**
- ☐ Peripheral Vascular Disease

☐ Pulmonary Hypertension
- ☐ Valvular Disease

☒ **Other**

Cardiomyopathy

Describe

- ☒ **Active**

☐ History of

☐ Rule out

Supported by

- ☒ **Echo**

☒ **Cardiac Cath**

☐ Other

Secondary to Hypertension

- ☐ yes

☐ No

comments

unknown

Congestive Heart Failure

Describe

- ☒ **Active**

☐ History of

☐ Rule out

Supported by

- ☐ Ejection fraction

☒ **Cardiomegaly**

☐ Orthopnea
- ☐ DOE

☐ PND

☐ S3
- ☐ Medications

☐ Peripheral edema

☐ Other

Describe

Diastolic

Systolic

Unknown

Secondary to Hypertension

Yes

No

Is patient on an ACE or ARB

Yes

No

Is patient on a Beta Blocker

Yes

No

Hyperlipidemia

Describe

Active

History of

Rule out

Supported by

Lab results

Medication

Other

Is patient on Statin

Yes

No

Ischemic Heart Disease (CAD)

Describe

Active

History of

Rule out

Supported by

Cardiac Cath

History of coronary stent

Diagnosis of angina

Medications

History of CABG

ECG

Other

Myocardial Infarction

Describe

Active (in past 28 days)

History of

Rule out

Supported by

ECG changes

Lab results

History of Hospitalization / Procedure for MI

Medications

Other

Is patient taking a Beta Blocker

Yes

No

Is patient taking

Aspirin

Plavix

Nitrate

Other

Other

Describe

comments

Eliquis

Other

Describe

Active

History of

Rule out

Supported by

History

Symptoms

Physical Findings

Medications


Test results

Image studies

Biopsy

DME

Other



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Other

comments

orthostatic hypotension. states this is improving and is only taking Midodrine once daily rather than TID as prescribed.

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

comments

two

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

☐ Celiac Disease

☐ Colon Polyps

☐ Gall Bladder Disease

☒ GERD

☐ Inflammatory Bowel Disease

☐ Ulcer Disease
- ☐ Cachexia

☐ Cirrhosis

☐ Diverticulitis

☐ Gastroparesis

☐ Hepatitis

☐ Pancreatitis

☐ Other

GERD

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Heartburn /
Dyspepsia

☐ Other

☐ Regurgitation

☒ Medications

History of blood in stool

☐ Yes

☒ No

History of black stools

☐ Yes ☒ No

History of Heartburn / Dyspepsia

☒ Yes ☐ No

☐ Describe

☒ Occasionally ☐ Chronic

comments

improved with medication

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

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

☒ Yes ☐ No

☐ Diagnoses

☐ Alcohol Dependence
☐ Bipolar Disorder
☐ Cerebral Palsy
☐ Dementia

☐ Amyotrophic Lateral Sclerosis
☐ Cerebral Hemorrhage
☐ Delusional Disease
☒ Depression

- ☐ Drug Dependence

☐ Generalized Anxiety Disorder

☐ Hemiparesis

☐ Insomnia

☐ Migraine Headaches

☐ Muscular Dystrophy

☐ Parkinson's disease

☐ Restless leg syndrome

☐ Seizure Disorder

☒ **Stroke**

☐ TIA

☐ Other

Depression

Describe

☒ **Active**
- ☐ Fibromyalgia

☐ Guillain-Barre Disease

☐ Huntington's Chorea

☐ Intellectual and or Developmental Disability

☐ Multiple Sclerosis

☐ Myasthenia Gravis

☒ **Peripheral Neuropathy**

☐ Schizophrenia

☐ Spinal Cord Injury

☐ Subdural Hematoma

☐ Traumatic Brain Injury

History of

☐ Rule out

comments

worsening depression symptoms and was hospitalized in March due to this. Duloxetine dose was increased at that point and symptoms have improved.

- Supported by

☐ Symptoms

☐ PHQ 2 / 9

☒ **Use of antidepressant medication**

Other

Major

☒ **Yes**

Supported by

☐ PHQ 9

☐ Hospitalization

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

Use of ECT

Peripheral Neuropathy

Describe

☒ **Active**

Supported by

☒ **Physical findings**

☐ EMG / Nerve Conduction studies

☐ Biopsy

Other

Secondary to Diabetes

☒ **Yes**

Stroke

Describe

☒ **Active**

Supported by


☒ **Hospitalization**

☐ Sensory findings

☐ Physical findings

History of

☐ Rule out

 FOCUSCARE

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Physical findings

- | | | |
|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Right arm paralysis | <input type="checkbox"/> Left arm paralysis |
| <input type="checkbox"/> Right leg paralysis | <input type="checkbox"/> Left leg paralysis | <input type="checkbox"/> Right hemiparesis |
| <input checked="" type="checkbox"/> Left hemiparesis | <input type="checkbox"/> Aphasia | <input type="checkbox"/> Apraxia |
| <input type="checkbox"/> Cranial nerve paralysis | <input type="checkbox"/> Functional Quadriplegia | |

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

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

- ☐ Yes ☒ No

Do you trouble understanding what people say to you?

- ☐ Yes ☒ No

Do your hands shake?

- ☐ Yes ☒ No

Do you have convulsions and seizures?

- ☐ Yes ☒ No

Do you have trouble with your memory?

- ☒ Yes ☐ No

Do you have trouble finding words?

- ☒ Yes ☐ No

Do you have trouble sleeping?

- ☐ Yes ☒ No

Have you lost your appetite

- ☐ Yes ☒ No

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

- ☐ Yes ☒ No

Do you have highs and lows

☒ Yes ☐ No

Do you ever feel like someone is out to get you

☐ Yes ☒ No

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

☐ Often ☒ Sometimes ☐ Never

GPCOG Score or MMSE Score

| GPCOG Score | or MMSE Score |
|-------------|---------------|
| | |

If GPCOG or MMSE is not done, is

↳ Patient oriented to person

☒ Yes ☐ No

↳ Patient oriented to place

☒ Yes ☐ No

↳ Patient oriented to time

☒ Yes ☐ No

↳ Recall

☒ Good ☐ Poor

↳ Patient describes recent news event

☒ Yes ☐ Partially ☐ No

Affect

☒ Normal ☐ Abnormal

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

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

PHQ 2 Score

☒ < 3 ☐ 3 or more

Speech

☐ Normal ☒ Slurred ☐ Aphasic
☐ Apraxia

comments

very slightly slurred with mild hesitation with word finding

Finger to Nose

☒ Normal ☐ Abnormal

Heel (Shin) to Toe

☒ Normal ☐ Abnormal

Thumb to Finger Tips

- ☒ Normal
- ☐ Abnormal

Sitting to Standing

- ☐ Normal
- ☒ Needs Assistance
- ☐ Unable

comments

uses walker with sitting to standing

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

comments

slow gait with walker, he states he feels his equilibrium is "off" when walking.

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

Acute Renal Failure

Describe

- ☐ Active
- ☒ History of
- ☐ Rule out

Supported by

- ☐ Lab tests
- ☐ Calculated GFR
- ☐ Hospitalization
- ☒ Other

Other

Describe

comments

pt had AKI requiring HD with hospitalization in March. Received dialysis while hospitalized and at out patient center 3-4 times. AKI resolved and dialysis catheter was removed. Patient unsure status of CKD at this time.

Etiology

comments

as above.

BPH

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

↳ **Supported by**

- ☐ Physical exam
- ☐ Biopsy
- ☐ Other

- ☐ Symptoms
- ☒ **Medication**

- ☐ Lab test
- ☐ Hospitalization

History of frequency

- ☐ Yes
- ☒ **No**

History of Nocturia

- ☐ Yes
- ☒ **No**

History of Hesitancy

- ☐ Yes
- ☒ **No**

Do you have trouble urinating?

- ☐ Yes
- ☒ **No**

Do you ever have blood in your urine?

- ☐ Yes
- ☒ **No**

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

- ☐ Yes
- ☒ **No**

Do you have trouble holding your urine?

- ☐ Yes
- ☒ **No**

Do you trouble getting to the bathroom on time?

- ☐ Yes
- ☒ **No**

Do you ever have pain or burning during urination?

- ☐ Yes
- ☒ **No**

Do you ever wear pads or diapers?

- ☐ Yes
- ☒ **No**

Do you have a vaginal discharge?

- ☐ Yes
- ☒ **No**

Do you have vaginal bleeding?

- ☐ Yes
- ☒ **No**

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

- ☐ Yes
- ☒ **No**

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

- ☐ Yes
- ☒ **No**

Endocrine Problems

- ☒ **Yes**
- ☐ No

↳ **Diagnoses**

- ☐ Chronic Kidney Disease secondary to Diabetes
- ☐ Cushing's Disease
- ☒ **Diabetic Retinopathy**
- ☐ Hypertension and Diabetes
- ☐ Hypothyroidism
- ☒ **Peripheral Neuropathy secondary to Diabetes**
- ☐ Coronary Artery Disease and Diabetes
- ☒ **Diabetes**
- ☐ Secondary Hyperparathyroidism
- ☐ Hyperthyroidism
- ☐ Kidney Stone
- ☐ Peripheral Vascular Disease secondary to Diabetes

- ☐ Hyperparathyroidism
- ☐ Other
- Diabetes**
 - ↳ Describe
 - ☒ Active
 - ☐ History of
 - ☐ Rule out
 - ↳ Supported by
 - ☐ Symptoms
 - ☐ Physical findings
 - ☐ Lab tests
 - ☒ Medications
 - ☐ Other
 - ↳ Type
 - ☐ Type 1
 - ☒ Type 2
 - ☐ Gestational
 - ↳ Most recent Hb A1C, value

comments

↳ And Date

comments

- ↳ Met with a nurse or dietician for diabetic education
 - ☒ Yes
 - ☐ No
- ↳ Met with a diabetic educator
 - ☒ Yes
 - ☐ No
- ↳ Treatment includes
 - ☐ Diet
 - ☐ Oral hypoglycemic agent
 - ☒ Insulin
 - ☐ Exercise
 - ☐ Weight loss

comments

Diabetic Retinopathy

- ↳ Describe
 - ☒ Active
 - ☐ History of
 - ☐ Rule out
- ↳ Supported by
 - ☒ Funduscopy exam
 - ☐ Vision loss
 - ☐ Laser Therapy
 - ☒ Retinal Injections
 - ☐ Surgical procedure
 - ☐ Other
- ↳ Patient sees Ophthalmologist
 - ☐ Occasionally
 - ☐ Once a year
 - ☒ Twice a year
 - ☐ >Twice a year

Peripheral Neuropathy secondary to Diabetes

- ↳ Describe
 - ☒ Active
 - ☐ History of
 - ☐ Rule out
- ↳ Supported by
 - ☒ Physical exam
 - ☐ Skin lesions
 - ☐ Foot deformity
 - ☐ Surgical procedures
 - ☐ Other
- ↳ Patient sees Podiatrist
 - ☐ Yes
 - ☒ No

Do you periodically experience shakiness, lightheadedness, sweating, confusion, or blurred vision?

☒ Yes ☐ No

Do you often feel thirsty?

☐ Yes ☒ No

Do you have numbness or burning in your legs or feet?

☒ Yes ☐ No

Do you get pains in your leg or feet when you walk?

☐ Yes ☒ No

Do you get ulcers on your legs or feet?

☐ Yes ☒ No

Do you feel sluggish?

☐ Yes ☒ No

Do you sweat a lot or constantly feel hot?

☐ Yes ☒ No

Have you been told your kidneys are not working right, failing or shutting down?

☒ Yes ☐ No

Have you ever had dialysis?

☒ Yes ☐ No

comments

see comment above

Is your skin itchy?

☐ Yes ☒ No

Do you test your blood sugar?

☒ Yes ☐ No

Have you lost weight in the past 6 months?

☐ None ☒ 5lbs ☐ 10lbs
☐ 15lbs ☐ More than 15lbs ☐ 10% of your weight
 (calculated by assessor)

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

☐ Yes ☒ No

Cancer

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

Pain

Does the patient experience pain?

☐ Yes ☒ No

Vital Signs

Vital Signs

| Blood Pressure | | Pulse | Respiratory Rate | Temp | Pulse Oximetry | Pain Scale /10 |
|----------------|-----------|----------|------------------|------|----------------|----------------|
| 140 (mmHG) | 84 (mmHG) | 83 (bpm) | 12 | 97.7 | 96 | 0/10 |

BMI

| Patients Height | | Patients Weight | Calculate BMI |
|-----------------|----------|-----------------|---------------|
| 5 (Feet) | 8 (Inch) | 246 (lbs) | 37.4 |

- ☐ 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 |
|-------------------------------|--------|----------|

Comment: slight decrease in nasal labia fold on left

| | | |
|------------------------------------|--------|----------|
| Palpation of the face and sinuses: | Normal | Abnormal |
|------------------------------------|--------|----------|

Eyes

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

Ears, Nose, Mouth and Throat

| | | |
|--|--------|----------|
| External Inspection of ears and nose: | Normal | Abnormal |
| Otoscopic examination: | Normal | Abnormal |
| Assessment of hearing: | Normal | Abnormal |
| Inspection of nasal mucosa, septum and turbinates: | Normal | Abnormal |
| Inspection of lips, teeth and gums: | Normal | Abnormal |
| 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 |
| Comment: +1 DP and PT | | |
| 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 |
| Comment: ambulates with walker | | |
| 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 |
| Comment: reports instability with walking. Pt swayed in chair with eyes closed | | |
| Assessment of muscle strength/tone: | Normal | Abnormal |
| Comment: no drift noted in LUE but has slightly weaker hand grasp on left compared to right, pt is left handed. | | |

Skin

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

Neurologic

Indicate specific cranial nerve tested

| |
|---|
| II: visual acuity III: EOM intact IV: EOM intact V: sensation intact to light touch on face VI: EOM intact VII: symmetric eye closing, symmetric facial movement VIII: hearing intact on gross exam X: uvula midline |
|---|

XI: shoulder shrugs equal bilaterally
XII: full ROM with tongue

Indicate cranial nerve deficits found

none

| | | |
|--|--------|----------|
| Romberg Test | Normal | Abnormal |
| Comment: not tested due to pts inability to sit in chair without swaying. | | |
| Examination of reflexes: | Normal | Abnormal |
| Comment: +1 BUE, not appreciated in lower extremities at Patella and ankle | | |
| Examination of sensation: | Normal | Abnormal |
| Comment: decreased to light touch in feet bilaterally | | |
| Coordination: | Normal | Abnormal |
| Comment: no past pointing on finger to knows but movement on left was slower | | |

Diabetes

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

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 | Select | | | No | | | | |
| DEXA | No | Select | | | Select | | | | |
| PAD | No | Select | | | No | | | | |
| LDL | N/A | Select | | | No | | | | |

Mini-Cog

39. Mini- Cog (see attached sheet)

| | | |
|--|-----|----|
| e. Do you have handrails on staircases? | Yes | No |
| Comment: no stairs | | |
| f. Is your hot water heater set for a maximum of 120 degrees? | Yes | No |
| Comment: unknown | | |
| g. Do you have smoke detectors on each level of the house and in all sleeping a rooms? | Yes | No |
| h. Do you have carbon Monoxide detectors on each level of the house? | Yes | No |
| i. Have used established an escape route in the event of fire? | Yes | No |

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

no
43. Is there anything that you could do to improve your quality of life?

nothing
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 :


Face to Face visit was completed. Pt was identified with name and date of birth. Pt verbally provided their height and weight. Any blanks left in this assessment were unable to be completed during this assessment today. Pt was informed that their PCP would receive a copy of this assessment.

Pt has had very complicated year with regards to medical health. Had stroke and MI requiring multiple hospitalizations. Had AKI requiring temporary dialysis, this has resolved, pt unsure if he has CKD. Pt currently on duel antiplatelet therapy with Plavix and Eliquis. He states that due to being on a fixed budget, he is not going to be able to afford Eliquis next month and is wanted to talk to someone at Optima regarding coverage for this.

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 : | 2021-07-12T11:00 |
| Time exam finished | 2021-07-12T12:49 |
| I accept the Disclosure Statement | <input checked="" type="checkbox"/> |
| Preventative Care checklist reviewed and left with member | <input type="checkbox"/> |
| Provider Signature | <div><div>Jennifer Edwards</div><div>Digitally signed by Jennifer E Edwards, AGNP 2021-07-12, 12:51</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?