

HRA Form

Health Plan :	Optima Health
Member Name :	JOHN E HALL
Evaluator Name :	test clinicianFE, FNP
Assessment Type :	Health Risk Assessment
DOB :	1947-11-08
Evaluation Date :	2022-4-1 09:05 AM
Visit Type :	In Person

Demographics

Plan	OHP
Program	MEDICARE
LOB	DSNP
Name	JOHN E HALL
Gender	Male
Address	1037 LARK ST
City	BEDFORD
State	VA
Zip	24523-9998
Date of Birth	1947-11-08
Age(as of date)	74
Marital Status	
Member Identification Number	900039655*01
HICN	
Phone Number	540/297-4031
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	
Phone Number	
Primary Care Physician	DEHLI, TODD H MD
Phone Number	
PCP Address	4830 RUCKER RD
PCP City	MONETA
PCP State	VA

PCP Zip	24121
PCP County	
Office ID	
Office Name	CENTRA MEDICAL GROUP LLC

1. Race

- ☐ Caucasian
 ☐ African American
 ☐ Asian
- ☐ Latino
 ☐ Native American
 ☐ Native Hawaiian or other Pacific Islander
- ☐ Alaskan Native
 ☒ Other
- ☐ Describe
No Ethnicity

Patient's Ethnicity

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

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

How much school have you completed?

- ☐ Completed less than 3rd grade
 ☐ Completed less than 8th grade
 ☒ Completed less than 12th grade

☐ Completed 12th grade, or attended College

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

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

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

☐ Very difficult ☐ Somewhat difficult ☐ Easy
☐ Very easy to understand

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

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

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

☐ Excellent ☒ **Good** ☐ Fair
☐ Poor

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

Where do you currently live?

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

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

☐ Yes ☒ **No**

Who do you currently live with?

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

Are you currently a caregiver for someone?

☐ Yes ☒ **No**

Are you currently employed?

☐ Yes ☒ **No**


Are you interested in employment?

☐ Yes ☒ **No**

Do you volunteer currently?

☐ Yes ☐ No

Tobacco use

☒ **Current** ☐ Former ☐ Never
 Type

☐ Cigarettes
 ☒ Cigars
 ☐ Chewing Tobacco
☐ Vaping
 ☐ Other

☒ Discussed smoking cessation options, member verbalized understanding

Alcohol Use

☐ Current
 ☐ Former
 ☒ Never

Do you or have you used recreational drugs?

☐ Yes
 ☒ No

Do you have a Healthcare Proxy?

☒ Yes
 ☐ No
 ☐ Don't Know

Name

no

Relationship

Son

Do you have a Durable Power of Attorney?

☐ Yes
 ☐ No
 ☒ Don't Know

Do you have an Advance Directive?

☐ Yes
 ☐ No
 ☒ Don't Know

Within the past 12 months we worried whether our food would run out before we got money to buy more. Was that _____ for your household?

☐ Often True
 ☒ Sometimes True
 ☐ Never True

Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Was that _____ for your household?

☐ Often True
 ☐ Sometimes True
 ☒ Never True

Recommendations

☒ Smoking/Tobacco
☐ Substance Abuse
☒ Durable Power of attorney
☐ Healthcare Proxy
☒ Advanced Directive
☐ Food Disparity
☒ Literacy
☒ Social support evaluation

Activities of Daily Living

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
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📌 How many stairs can you climb

- ☐ None
 ☐ Three to five
 ☒ Six to ten
 ☐ More than ten

Medical History

Do you use any assistive devices or DME?

- ☒ None

Are you currently seeing any specialists?

- ☐ Yes
 ☒ No

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

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

- ☐ Yes
 ☒ No

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
Adult Day Care	Yes	No

In the past year 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

Family History

☐ Yes

☒ No

Preventive Care

In the past three years have you had?

Screen	Answer	Date	Method	Recommendation	Education Completed
Breast Cancer Screening	No			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Colorectal Screening				<input type="checkbox"/>	<input type="checkbox"/>
Influenza Vaccine	No		N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
COVID-19 Vaccine	Not Applicable		N/A	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal Vaccine	Don't Know		N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Herpes Zoster Vaccine			N/A	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Screening	No		N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Diabetic Foot Exam			N/A	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol Screening	Yes		N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Glaucoma Screening			N/A	<input type="checkbox"/>	<input type="checkbox"/>
STIs/HIV Screening	No		N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Cervical Cancer Screening	Don't Know		N/A	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Osteoporosis Screening	Yes			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prostate Screening	Not Applicable		N/A	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Fall Risk Screening	Don't Know		N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

☐ Yes ☐ No ☒ NA

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

☐ Yes ☐ No ☒ NA

Recommendations

- ☒ Abdominal Aneurysm Screening
- ☐ Hepatitis C Screening

Allergies / Medications

35. Allergies

☐ Yes ☒ No

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status
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36. Over the Counter Medications / Supplements

☐ Yes ☒ No

Long Term Use of:

- ☐ None
- ☒ ASA ☒ Steroids ☐ Insulin
☐ Anticoagulants ☐ Statins ☐ Biphosphonate

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
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Recommendations

- ☒ Discuss options with your Doctor and/or pharmacist to improve medication adherence
- ☒ Discuss medication side effects with your Doctor
- ☒ Other
- ☐ Educated on importance of medication compliance, member verbalizes understanding

Review of Systems and Diagnoses

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

☒ Yes

☐ No

Diagnoses

☐ Cataracts

☒ Hyperopia

☐ Macular Degeneration

☒ Retinal Disease

Glaucoma

Which Eye

☐ Right Eye

☒ Left Eye

☐ Both

Describe

☐ Active

☐ History of

☒ Rule out

Supported by

☐ History

☐ Medications

☒ Biopsy

☐ Symptoms

Type

☒ Pain

☐ Dry eye

☐ Tearing

☐ Problem seeing at night

☐ Floaters

Secondary to Diabetes

☐ Yes

☒ No

Hyperopia

Which Eye

☒ Right Eye

☐ Left Eye

☐ Both

Describe

☐ Active

☐ History of

☒ Rule out

Supported by

☐ History

☐ Medications

☐ Biopsy

☐ Symptoms


Type

☒ Glaucoma

☐ Legally Blind

☐ Myopia

☐ Others



FOCUSCARE

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☐ Pain
 ☒ Dry eye
 ☐ Tearing

☐ Problem seeing at night
 ☐ Floaters

Retinal Disease

☐ Which Eye
 ☐ Right Eye
 ☒ Left Eye
 ☐ Both

☐ Describe
 ☐ Active
 ☐ History of
 ☐ Rule out

☐ Supported by
 ☒ History
 ☐ Medications
 ☐ Test results
 ☒ Physical Findings
 ☐ Image studies
 ☐ Biopsy
 ☐ DME
 ☐ Other

☐ Secondary to Diabetes
 ☐ Yes
 ☒ No

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

```
graph TD
    Q1[Yes/No] --> D[Diagnoses]
    D --> D1[Difficulty with Hearing]
    D --> D2[Tinnitus]
    D --> D3[Other]
    D2 --> LD[Legally Deaf]
    LD --> D2D[Describe]
    D2D --> D2DA[Active]
    D2DA --> D2DS[Supported by]
    D2DS --> D2DSH[History]
    D2DS --> D2DSM[Medications]
    D2DS --> D2DSB[Biopsy]
    D2DSH --> D2DSH1[History of]
    D2DSH --> D2DSH2[Symptoms]
    D2DSH --> D2DSH3[Test results]
    D2DSH --> D2DSH4[DME]
    D2DSH1 --> D2DSH1R[Rule out]
    D2DSH2 --> D2DSH2P[Physical Findings]
    D2DSH2 --> D2DSH2IS[Image studies]
    D2DSH2 --> D2DSH2O[Other]
    D2DSM --> D2DSM1[History of]
    D2DSM --> D2DSM2[Symptoms]
    D2DSM --> D2DSM3[Test results]
    D2DSM3 --> D2DSM3P[Physical Findings]
    D2DSM3 --> D2DSM3IS[Image studies]
    D2DSM3 --> D2DSM3O[Other]
```

The flowchart for Diagnoses starts with a decision point: Yes (green square) or No (grey square). If Yes, it leads to Diagnoses (blue arrow), which branches into Difficulty with Hearing, Tinnitus (green square), and Other. Tinnitus leads to Legally Deaf (green square), which then leads to Describe (blue arrow). Describe branches into Active, which leads to Supported by (blue arrow). Supported by branches into History, Medications, and Biopsy. History leads to History of (grey square), which branches into Rule out (grey square), Physical Findings (green square), Image studies (green square), and Other (grey square). Medications leads to History of (grey square), which branches into Rule out (grey square), Physical Findings (green square), Image studies (green square), and Other (grey square). Biopsy leads to History of (grey square), which branches into Rule out (grey square), Physical Findings (green square), Image studies (green square), and Other (grey square).

Nose Problems (Nose Bleeds, Sinus infections, Other)

```
graph TD
    Q1[Do you have any of the following symptoms?] -- Yes --> D1[Diagnoses]
    Q1 -- No --> D2[Chronic Post Nasal Drip]
    D1 --> D1_1[Allergic Rhinitis]
    D1 --> D1_2[Nose Bleeds]
    D1 --> D1_3[Sinus Infections]
    D1 --> D1_4[Other]
    D1_2 --> D1_2_1[Nose Bleeds]
    D1_2_1 --> D1_2_1_1[Describe]
    D1_2_1_1 --> D1_2_1_1_1[Active]
    D1_2_1_1_1 --> D1_2_1_1_1_1[Seasonal Allergies]
    D1_2_1_1_1_1 --> D1_2_1_1_1_1_1[Describe]
    D1_2_1_1_1_1_1 --> D1_2_1_1_1_1_1_1[History of]
    D1_2_1_1_1_1_1_1 --> D1_2_1_1_1_1_1_1_1[Rule out]
```

Flowchart for Allergic Rhinitis diagnosis:

- Do you have any of the following symptoms?
 - Yes**:
 - Diagnoses**
 - Allergic Rhinitis
 - Nose Bleeds**
 - Nose Bleeds**
 - Describe**
 - Active**
 - Seasonal Allergies**
 - Describe**
 - History of**
 - Rule out**
 - Sinus Infections
 - Other**
 - No**:
 - Chronic Post Nasal Drip
 - Seasonal Allergies**
 - Sinusitis

- ☐ Active
- ↳ **Supported by**
 - ☐ History
 - ☐ Medications
 - ☐ Biopsy

Other

- ↳ **Describe**
 - ☐ Active
- ↳ **Supported by**
 - ☐ History
 - ☐ Medications
 - ☐ Biopsy

↳ **Other**

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

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

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

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

comments

OTHERS

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

- ☒ **Yes**
- ☐ No

↳ **Diagnoses**

- ☒ **Bleeding Gums**
- ☒ **Difficulty Swallowing**
- ☐ Difficulty Chewing
- ☐ Other

Bleeding Gums

↳ **Describe**

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

Difficulty Swallowing

↳ **Describe**

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

↳ **Have you had a stroke**

- ☐ Yes
- ☒ **No**

Neck Problems (parotid Disease, Carotid Stenosis, Other)

- ☒ **Yes**
- ☐ No

↳ **Diagnoses**

- ☐ Carotid Stenosis
- ☒ **Parotid Disease**
- ☐ Other

Parotid Disease

↳ **Describe**

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

↳ **Supported by**

- ☐ Physical findings
- ☒ **History**
- ☐ Other

Recommendations

- ☒ **Hearing evaluation**
- ☐ Dental exam
- ☒ **Eye exam**
- ☐ Swallowing evaluation
- ☒ **Take medications as prescribed**
- ☒ **Other**

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

☒ Yes

☐ No

Diagnoses

- ☐ Acute Pulmonary Embolism
- ☐ Asthma
- ☐ Chronic Respiratory Failure
- ☐ COPD
- ☐ Hypoventilation secondary to Obesity
- ☐ Pneumonia
- ☐ Respirator Dependence/Tracheostomy Status
- ☐ Sarcoidosis
- ☐ Other
- ☒ Acute Upper Respiratory Infection
- ☐ Chronic Pulmonary Embolism
- ☐ Chronic Sputum Production
- ☒ Cystic Fibrosis
- ☐ Hypoxemia
- ☒ Pulmonary Fibrosis
- ☐ Respiratory Arrest
- ☐ Sleep Apnea

Acute Upper Respiratory Infection

Describe

☐ Active

☐ History of

☒ Rule out

Supported by

☐ Fever

☒ Chills

☐ Cough

☐ Decreased breathe sounds

☐ Rales

☐ Wheezing

☐ Chest X-ray

☐ Shortness of breath

☐ Chronic cough

☒ Other

Other

Describe

comments

OTHERS

Cystic Fibrosis

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☒ History

☐ Medications

☐ Biopsy

☐ Wheezing

☐ Symptoms

☐ Test results

☒ DME

☒ Chronic cough

☐ Rule out

☒ Physical Findings

☒ Image studies

☐ Shortness of breath

☐ Other

Pulmonary Fibrosis

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☐ X-ray or CT results

☒ PFT

☐ Biopsy

☐ Medications

☐ Shortness of breath

☐ Wheezing

☒ Chronic cough

☐ Other

Recommendations

- ☒ Take medications as prescribed
- ☒ Other

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

Infarction, Other)

☒ Yes ☐ No

Diagnoses

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

Aneurysm

Describe

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

Supported by

- | | | |
|--|---|---|
| <input type="checkbox"/> Physical exam | <input checked="" type="checkbox"/> Ultra sound, last study date & size | <input checked="" type="checkbox"/> Image studies |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Light headedness | <input checked="" type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Other |

Describe

- | | | |
|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Abdominal | <input type="checkbox"/> Thoracic | <input checked="" type="checkbox"/> Peripheral |
|------------------------------------|-----------------------------------|--|

Atrial Fibrillation

Describe

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

Type

- | | | |
|-------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Paroxysmal | <input type="checkbox"/> Chronic | <input checked="" type="checkbox"/> Unknown |
|-------------------------------------|----------------------------------|---|

Supported by

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Medications | <input type="checkbox"/> ECG | <input type="checkbox"/> Symptoms |
| <input type="checkbox"/> History | <input type="checkbox"/> Electric cardioversion | <input checked="" type="checkbox"/> Chest pain |
| <input type="checkbox"/> Light headedness | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing |
| <input checked="" type="checkbox"/> Chronic cough | <input type="checkbox"/> Other | |

Is patient taking

- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> Anticoagulant | <input type="checkbox"/> Rate controlling medication | <input type="checkbox"/> Other |
|--|--|--------------------------------|

Deep Vein Thrombosis

Describe

- | | |
|--------------------------------|---|
| <input type="checkbox"/> Acute | <input checked="" type="checkbox"/> Chronic |
|--------------------------------|---|

Describe

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

Supported by

- | | | |
|---|---|--|
| <input type="checkbox"/> Physical findings | <input type="checkbox"/> Use of anticoagulation | <input checked="" type="checkbox"/> Vascular studies |
| <input type="checkbox"/> Vena Cava filter | <input type="checkbox"/> Edema | <input checked="" type="checkbox"/> Chest pain |
| <input type="checkbox"/> Light headedness | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing |
| <input checked="" type="checkbox"/> Chronic cough | <input type="checkbox"/> Other | |

↳ Persistent for three months or more

☐ Yes ☐ No

Ischemic Heart Disease (CAD)

↳ Describe

☐ Active ☒ History of ☐ Rule out

↳ Supported by

☐ Cardiac Cath ☒ History of coronary ☐ Diagnosis of angina
☐ Medications ☐ History of CABG ☐ ECG
☒ Chest pain ☐ Light headedness ☒ Shortness of breath
☐ Wheezing ☐ Chronic cough ☐ Other

Valvular Disease

↳ Describe

☐ Active ☒ History of ☐ Rule out

↳ Supported by

☐ History ☒ Symptoms ☐ Physical Findings
☒ Medications ☐ Test results ☐ Image studies
☒ Biopsy ☐ DME ☒ Chest pain
☐ Light headedness ☒ Shortness of breath ☐ Wheezing
☐ Chronic cough ☐ Other

↳ Describe

☒ Mitral Stenosis ☐ Aortic Stenosis / ☐ Tricuspid Stenosis
☐ Pulmonary Insufficiency ☐ Pulmonary Stenosis ☐ Aortic Insufficiency
☐ Mitral Insufficiency / ☐ Tricuspid Insufficiency
☐ Prolapse

↳ Valve replacement

☒ Yes ☐ No

↳ Which valve, type of replacement

↳ Is patient on anticoagulation

☐ Yes ☒ No

Other

↳ Describe

☐ Active ☒ History of ☐ Rule out

↳ Supported by

☒ History ☐ Symptoms ☒ Physical Findings
☐ Medications ☐ Test results ☒ Image studies
☐ Biopsy ☒ DME ☐ Chest pain
☐ Light headedness ☒ Shortness of breath ☐ Wheezing
☐ Chronic cough ☐ Other

↳ Other

Recommendations

- ☒ Blood Pressure checks
- ☐ Heart Healthy Diet
- ☒ Exercise 30 min a day

- ☒ **Take medications as prescribed**
☐ Other

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

- ☐ Yes ☒ **No**

Recommendations

- ☒ **Take medications as prescribed**
☒ **Other**

Bowel Movements

- ☐ Normal ☒ **Abnormal**
↳ If abnormal
☒ **Constipation** ☐ Diarrhea ☐ Bowel Incontinence

Abdominal Openings

- ☒ **Yes** ☐ No
↳ Describe
☐ Ileostomy ☒ **Colostomy** ☐ Urostomy
☐ PEG ☐ Cystostomy

Rectal Problems

- ☐ Yes ☒ **No**

Last Bowel Movement

- ☐ Today ☐ 1-3 days ago ☒ **>3 days ago**

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

- ☐ Yes ☒ **No**

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

- ☒ **Yes** ☐ No

Do you worry too much about different things?

- ☒ **Yes** ☐ No

Do you feel afraid that something bad might happen?

- ☒ **Yes** ☐ No

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

- ☐ Often ☐ Sometimes ☒ **Never**

GPCOG Score or MMSE Score

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

If GPCOG or MMSE is not done, is

- ↳ Patient oriented to person
☐ Yes ☒ **No**
↳ Patient oriented to place
☐ Yes ☒ **No**

↳ Patient oriented to time

☒ Yes

☐ No

↳ Recall

☐ Good

☒ Poor

↳ Patient describes recent news event

☐ Yes

☒ Partially

☐ No

Affect

☐ Normal

☒ Abnormal

↳ If abnormal,

☐ Paranoia

☒ Delusional

☐ Disorganized thought

☐ Flat

☐ Manic

☐ Depressed

☐ Other

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

| | | | | |
|---|--|---------------------------------------|--|---|
| Little interest or pleasure in doing things | <input checked="" type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than half the days | <input type="checkbox"/> Nearly every day |
| Feeling down, depressed or hopeless | <input checked="" type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than half the days | <input type="checkbox"/> Nearly every day |

PHQ 2 Score

☒ < 3

☐ 3 or more

Speech

☐ Normal

☒ Slurred

☐ Aphasic

☐ Apraxia

Finger to Nose

☐ Normal

☐ Abnormal

Heel (Shin) to Toe

☒ Normal

☐ Abnormal

Thumb to Finger Tips

☒ Normal

☐ Abnormal

Sitting to Standing

☒ Normal

☐ Needs Assistance

☐ Unable

Facial / Extremity Movement

☐ Motor Tic

☐ Vocal Tic

☐ Benign (Essential Tremor)

☐ Intention Tremor

☐ Non-Intention (Pill rolling) Tremor

☐ Rigidity

☐ Spasticity

☐ Chorea Movement

☐ Cog wheeling

☐ Normal

Gait

☐ Normal

☒ Limp

☐ Wide based

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

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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

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

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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

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

Diagnoses

- | | |
|---|--|
| <input type="checkbox"/> Collagen (Connective) Tissue Disease | <input type="checkbox"/> Degenerative Disc Disease |
| <input type="checkbox"/> Extremity Fracture | <input checked="" type="checkbox"/> Gout |
| <input type="checkbox"/> Hallux Valgus | <input type="checkbox"/> Hammer Toes |
| <input type="checkbox"/> Osteoarthritis | <input checked="" type="checkbox"/> Osteomyelitis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pyogenic Arthritis |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Spinal Stenosis |
| <input type="checkbox"/> Systemic Lupus Erythematosus | <input type="checkbox"/> Other |

Gout

Describe

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

Supported by

- | | | |
|---|------------------------------------|---|
| <input type="checkbox"/> History of attacks in Foot | <input type="checkbox"/> Lab tests | <input checked="" type="checkbox"/> Medications |
| <input type="checkbox"/> Other | | |

Osteomyelitis

Describe

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

Supported by

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Hospitalization | <input type="checkbox"/> Image studies | <input checked="" type="checkbox"/> Cultures |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Other | |

Have you had an amputation?

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

☐ Describe
yes

Recommendations

- ☒ Discuss PT/OT evaluation with PCP

- ☐ Take medications as prescribed
- ☒ Other

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

- ☒ Yes
- ☐ No

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Basil Cell Carcinoma | <input type="checkbox"/> Dermatitis |
| <input checked="" type="checkbox"/> Eczema | <input type="checkbox"/> Onychomycosis |
| <input checked="" type="checkbox"/> Psoriasis | <input type="checkbox"/> Skin ulcer |
| <input type="checkbox"/> Tinea Pedis | <input type="checkbox"/> Urticarial Disease |
| <input checked="" type="checkbox"/> Wound | <input type="checkbox"/> Other |

Eczema

Describe

- ☐ Active

Supported by

- ☐ History
- ☐ Medications
- ☐ Biopsy

☒ History of

- ☐ Symptoms
- ☐ Test results
- ☐ DME

☐ Rule out

- ☐ Physical Findings
- ☒ Image studies
- ☐ Other

Psoriasis

Describe

- ☐ Active

Supported by

- ☒ History
- ☐ Medications
- ☐ Biopsy

☒ History of

- ☐ Symptoms
- ☐ Test results
- ☐ DME

☐ Rule out

- ☒ Physical Findings
- ☒ Image studies
- ☐ Other

History of Psoriatic Arthritis

- ☐ Yes

☒ No

Wound

Describe

- ☐ Active

Supported by

- ☐ History
- ☐ Medications
- ☐ Biopsy

☐ History of

- ☐ Symptoms
- ☐ Test results
- ☐ DME

☒ Rule out

- ☐ Physical Findings
- ☒ Image studies
- ☐ Other

Etiology

- ☐ Surgical

☐ Traumatic

☒ Burn

Recommendations

- ☒ Take medications as prescribed
- ☒ Other

Endocrine Problems

- ☒ Yes
- ☐ No

Diagnoses

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

- ☐ Hypertension and Diabetes
 ☒ **Hypothyroidism**
- ☐ Peripheral Vascular Disease secondary to Diabetes
 ☐ Other
 ☐ Cushing's Disease
 ☐ Describe

☐ Active
 ☒ **History of**
☐ Rule out

☐ Supported by
 ☐ Physical exam
 ☐ Other
 ☐ Lab tests
 ☒ **Suppression Test**
- ☐ Hypothyroidism
 ☐ Describe

☐ Active
 ☒ **History of**
☐ Rule out

☐ Supported by
 ☒ **Weight gain**
☐ Fatigue
 ☐ Treatment for hypothyroidism
 ☐ Depression
 ☐ Hair changes
 ☐ Lab data

☐ Other

Recommendations

- ☒ **Take medications as prescribed**
- ☒ **Check Blood sugar**
- ☒ **Other**

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

- ☐ Yes
- ☒ **No**

Recommendations

- ☒ **Take medications as prescribed**
- ☒ **Report abnormal bruising or bleeding**
- ☒ **Follow up with doctor for lab work**
- ☐ Other

Cancer

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

Describe

☐ Active
 ☒ **History of**
☐ Rule out

Supported by

☐ Physical findings
 ☐ Hospitalization
 ☒ **Treatments**
☐ Lab tests
 ☐ Imaging studies
 ☐ Surgery
 ☐ Biopsy
 ☐ Other

Type

☐ Brain
 ☒ **Head**
☐ Neck
 ☐ Breast
 ☐ Lung
 ☐ Esophagus

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

- ☐ Liver
- ☐ Rectum
- ☐ Ovaries
- ☐ Bone
- ☐ Skin

- ☐ Pancreas
- ☐ Kidney
- ☐ Uterus
- ☐ Blood
- ☐ Other

Specific type/s

Typed

Stage or Classification specific to the cancer

Cance

Active treatment

- ☐ Yes
- ☒ No

Is there a current finding of Metastasis?

- ☒ Yes
- ☐ No

Location

ju

History / finding of Cachexia

- ☒ Yes
- ☐ No

Do you see a specialist?

- ☒ Yes
- ☐ No

Provider

pro

Recommendations

- ☒ Take medications as prescribed
- ☒ Other

Pain

Does the patient experience pain?

- ☐ Yes
- ☒ No

Vital Signs

Vital Signs

| Blood Pressure | | Pulse | Respiratory Rate | Temp | Pulse Oximetry | Pain Scale /10 |
|----------------|-----------|-----------|------------------|------|----------------|----------------|
| 120 (mmHG) | 12 (mmHG) | 100 (bpm) | 123 | 90 | 10 | 2 |

BMI

| Patients Height | | Patients Weight | BMI |
|-----------------|-----------|-----------------|-----|
| 09 (Feet) | 10 (Inch) | 120 (lbs) | 6.1 |

- ☒ **Obesity**
☐ Malnutrition

☐ Moderate Obesity

☐ Morbid Obesity

Are you on a special diet?

- ☐ Heart Healthy Diet
☐ Vegetarian
☐ Keto

- ☐ Diabetic Diet
☐ Vegan
☐ Pescatarian

- ☒ **Renal Diet**
☐ Gluten Free
☐ Other

Have you lost weight in the past 6 months?

- ☐ None
☐ 15lbs

- ☒ **5lbs**
☐ More than 15lbs

- ☐ 10lbs
☐ 10% of your weight
(calculated by assessor)

Recommendations

- ☒ **Nutrition/ weight management**
☒ **Other**

Exam Review

Constitutional

| | | |
|---------------------|--------|----------|
| General appearance: | Normal | Abnormal |
|---------------------|--------|----------|

Head and Face

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

Eyes

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

Ears, Nose, Mouth and Throat

| | | |
|--|--------|----------|
| External Inspection of ears and nose: | Normal | Abnormal |
| Otoscopic examination: | Normal | Abnormal |
| Assessment of hearing: | Normal | Abnormal |
| Inspection of nasal mucosa, septum and trubينات: | 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 |
| Auscultation of lungs: | Normal | Abnormal |

Cardiovascular

| | | |
|---|--------|----------|
| Auscultation of heart: | Normal | Abnormal |
| Palpation and auscultation of Carotid Arteries: | Normal | Abnormal |
| Pedal Pulses: | Normal | Abnormal |
| Examination of Edema / Varicosities: | Normal | Abnormal |
| Examination of Radial Pulses: | Normal | Abnormal |

Lymphatic

| | | |
|--|--------|----------|
| Palpation of cervical nodes (neck) | Normal | Abnormal |
| Palpation of preauricular nodes (in front of the ears) | Normal | Abnormal |
| Palpation of Submandibular nodes (under jaw line/chin) | Normal | Abnormal |

Musculoskeletal

| | | |
|--|--------|----------|
| Examination of gait and station: | Normal | Abnormal |
| Inspection/palpation of digits and nails: | Normal | Abnormal |
| Inspection/palpation of joints, bones and muscles: | Normal | Abnormal |
| Assessment of range of motion: | Normal | Abnormal |
| Assessment of stability: | Normal | Abnormal |
| Assessment of muscle strength/tone: | Normal | Abnormal |

Skin

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

Neurologic

Indicate specific cranial nerve tested

Indicate cranial nerve deficits found

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

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

MICROALBUMIN

☐ Yes
 ☒ No

FOBT

☐ Yes
 ☒ No

A1C

☐ Yes
 ☒ No

LDL

☐ Yes
 ☒ No

RETINAL EYE EXAM

☐ Yes
 ☒ No

DEXA

☐ Yes
 ☒ No

PAD

☐ Yes
 ☒ No

☐ Member educated on results, verbalized understanding

Mini-Cog

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 : --

Person's Answers: --

| | | |
|---------------|-----------|---|
| Word Recall : | -- Points | 1 point for each word spontaneously recalled without cueing. Home Safety Yes |
| Clock Draw : | -- 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 : | -- 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. |

Recommendations

- ☒ **Further cognitive evaluation needed**
- ☐ Other

Home Safety & Personal Goals

In the past year how many times have you Fallen?

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

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 |

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

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

Have you ever physically or felt emotionally abused by someone

☐ Yes ☒ No

Feeling like harming others or yourself

☐ Yes ☐ No

Are you afraid of anyone or is anyone hurting you?


☐ Yes ☐ No

Patient Summary

Assessors Comments :

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 : | 2022-04-01T13:15 |
| Time exam finished | 2022-04-01T18:15 |
| I accept the Disclosure Statement | <input checked="" type="checkbox"/> |
| Provider Signature | <div> <div>shwe</div> <div>  <p>Digitally signed by
test
clinicianFE,
FNP
2022-04-01, 13:16</p> </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?

The information obtained today and any applicable lab results (some of which may become available after subsequent analysis) may be sent to your primary care physician (PCP).