

HRA Form

Health Plan :	Optima Health
Member Name :	NOTASHA D HAMMOCK
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1978-02-03
Evaluation Date :	2022-2-11 10:30 AM
Visit Type :	In Person

Demographics

Plan	OHP
Program	MEDICARE
LOB	DSNP
Name	NOTASHA D HAMMOCK
Gender	Female
Address	944 POLLARD ST
City	NORFOLK
State	VA
Zip	23504-9998
Date of Birth	1978-02-03
Age(as of date)	44
Marital Status	Single
Member Identification Number	900039986*01
HICN	
Phone Number	757/533-2069
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	Alexis Davis
Phone Number	412-207-7780
Primary Care Physician	MUSSELMANI, ZATTAM MD
Phone Number	757/543-3557
PCP Address	1422 POINDEXTER ST
PCP City	CHESAPEAKE
PCP State	VA

PCP Zip	23324
PCP County	
Office ID	
Office Name	ZATTAM MUSSELMANI

### 1. Race

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

### Patient's Ethnicity

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

### Preferred language

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

### Previously Documented Conditions

### Covid Screening

In the last 14 days, have you:

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

### Self-Assessment and Social History

How much school have you completed?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Completed less than 3rd grade                               | <input type="checkbox"/> Completed less than 8th grade | <input type="checkbox"/> Completed less than 12th grade |
| <input checked="" type="checkbox"/> <b>Completed 12th grade, or attended College</b> |  |   |

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

 Describe

not isolated, has contact with friends and family

Are you currently a caregiver for someone?

- ☐ Yes ☒ No

comments

has children who are not in her custody due to psych difficulties

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

↳ **How Many**

- ☐ 1 - 3 a day ☐ 1/2 a pack ☒ **1 pack**  
☐ More than 1 pack ☐ Other



- ☒ **Discussed smoking cessation options, member verbalized understanding**

### Alcohol Use

- ☐ Current ☐ Former ☒ **Never**

### Do you or have you used recreational drugs?

- ☒ **Yes** ☐ No

↳ **Which drugs**  
cannabis

### Do you have a Healthcare Proxy?

- ☐ Yes ☒ **No** ☐ Don't Know

### Do you have a Durable Power of Attorney?

- ☐ Yes ☒ **No** ☐ Don't Know

### Do you have an Advance Directive?

- ☐ Yes ☒ **No** ☐ Don't Know

- ☐ Member educated on advance care planning  
☐ Declines discussion at this time

### 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
H. Going up or down stairs	No	Need Some Help	Need Total Help

## Medical History

Do you use any assistive devices or DME?

☒ None

Are you currently seeing any specialists?

☒ Yes

☐ No

Medical Specialty	Specialist	For
Endocrinologist	Dr Mason	Type 2 DM
Gastroenterologist	Dr. Gamsey	GERD
Ophthalmologist	Dr ,	glaucoma
Other	Dr Jordan	OA
Psychiatrist	Dr. Angelleli	Schizoaffective disorder

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

 Describe

left total knee replacement

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

Comment: Lantus insulin; Haldol

Tube Feedings	Yes	No	Unknown
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## Family History

### Family History

☐ Yes ☒ No

comments did not provide

## Preventive Care

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

Screen	Answer	Date	Method	Recommendation	Education Completed
Breast Cancer Screening	Yes	11/16/21	mammogram	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Colorectal Screening	No			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Influenza Vaccine	Yes	2021	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
COVID-19 Vaccine	Yes	2021	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pneumococcal Vaccine	No	greater than 3 years	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Herpes Zoster	No		N/A		

Vaccine				<input type="checkbox"/>	<input checked="" type="checkbox"/>
Diabetes Screening	Yes	9/2021	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Diabetic Foot Exam	Yes	2021	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cholesterol Screening	Yes	11/2021	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Glaucoma Screening	Yes	2/2022	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
STIs/HIV Screening	Yes	2019	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cervical Cancer Screening	Yes	2021	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Osteoporosis Screening	No			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prostate Screening	Not Applicable		N/A	<input type="checkbox"/>	<input type="checkbox"/>
Fall Risk Screening	No		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

Substance	Reaction
seasonal/environmental allergies	cough, itchy eyes nasal congestion
PCN	itching

### Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status
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comments Gets haldol injection monthly at psychiatrist office

seasonal allergies	FLUTICASON E PROPIONATE	50MCG	N = Nasal	PRN	PCP	Taking	Not Taking
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Type 2 DM	JANUVIA	100MG	PO = By Mouth	QD	PCP	Taking	Not Taking
HLD	SIMVASTATIN	20MG	PO = By Mouth	HS	PCP	Taking	Not Taking
Type 2 DM	METFORMIN HYDROCHLORIDE ER	500MG ER	PO = By Mouth	BID	PCP	Taking	Not Taking
GERD	OMEPRAZOLE	40MG	PO = By Mouth	QD	PCP	Taking	Not Taking
insomnia	MIRTAZAPINE	30MG	PO = By Mouth	QD	Psychiatrist	Taking	Not Taking
Schizoaffective disorder	HALOPERIDOL	injection	PO = By Mouth	Select	Psychiatrist	Taking	Not Taking
Schizoaffective disorder	QUETIAPINE FUMARATE	600mg	PO = By Mouth	HS	Psychiatrist	Taking	Not Taking
Anemia	FERROUS SULFATE	325MG	PO = By Mouth	QD	PCP	Taking	Not Taking
insomnia	TRAZODONE HYDROCHLORIDE	100MG	PO = By Mouth	HS	Psychiatrist	Taking	Not Taking
Chronic pain/arthritis	NAPROXEN	500MG	PO = By Mouth	PRN	PCP	Taking	Not Taking
cough/seasonal allergies	SPIRIVA HANDIHALER	HANDIHLR	PO = By Mouth	QD	PCP	Taking	Not Taking
Back pain	LIDOCAINE	5%	T = Topical	PRN	PCP	Taking	Not Taking
HTN	LISINOPRIL	20MG	PO = By Mouth	QD	PCP	Taking	Not Taking
Type 2 DM	LANTUS SOLOSTAR	100/ML	SQ = Subcutaneous	HS	PCP	Taking	Not Taking
Chronic pain	TRAMADOL HCL	50MG	PO = By Mouth	PRN	PCP	Taking	Not Taking
Anxiety	LORAZEPAM	1MG	PO = By Mouth	BID	Psychiatrist	Taking	Not Taking
Pain	GABAPENTIN	300MG	PO = By Mouth	BID	PCP	Taking	Not Taking
Pain	ACETAMINOPHEN	325MG	PO = By Mouth	PRN	PCP	Taking	Not Taking
seasonal allergies	ALLERGY RELIEF D-12	5-120MG	PO = By Mouth	PRN	PCP	Taking	Not Taking
glaucoma	ROCKLATAN	0.2/0.5%	E = Eye	HS	Ophthalmology	Taking	Not Taking
GERD	SUCRALFATE	1GM/10ML	PO = By Mouth	BID	GI	Taking	Not Taking
pain/OA	ASPERCREME LIDOCAINE MAX STRENGTH	LIDO 4%	T = Topical	PRN	PCP	Taking	Not Taking
nausea	ONDANSETRON ODT	4MG ODT	PO = By Mouth	PRN	GI	Taking	Not Taking

36. Over the Counter Medications / Supplements

☐ Yes
☒ No



Long Term Use of:

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

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
- ☐ Legally Blind
- ☐ Myopia
- ☐ Others

comments

Cataracts listed in previously documented conditions. She denied having cataracts when asked; She also did not mention being legally blind when asked. Wears glasses

Glaucoma

Which Eye

- ☐ Right Eye
- ☐ Left Eye
- ☒ Both

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ History
- ☒ Medications
- ☐ Biopsy
- ☐ Symptoms
- ☒ Test results
- ☐ DME
- ☐ Physical Findings
- ☐ Image studies
- ☐ Other

### Secondary to Diabetes

☐ Yes ☐ No

comments

does not know

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

☐ Yes ☒ No

### Nose Problems (Nose Bleeds, Sinus infections, Other)

☒ Yes ☐ No

#### Diagnoses

☐ Allergic Rhinitis

☐ Nose Bleeds

☐ Sinus Infections

☐ Other

☐ Chronic Post Nasal Drip

☒ **Seasonal Allergies**

☐ Sinusitis

#### Seasonal Allergies

##### Describe

☒ **Active**

☐ History of

☐ Rule out

##### Supported by

☐ History

☒ **Symptoms**

☐ Physical Findings

☒ **Medications**

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

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

☐ Yes ☒ No

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

☐ Yes ☒ No

### 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

comments

Sleep apnea and COPD listed in previous conditions. She did not mention these conditions when asked

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

### Hyperlipidemia

#### Describe

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

#### Supported by

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Lab results      | <input checked="" type="checkbox"/> <b>Medication</b> | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Light headedness | <input type="checkbox"/> Shortness of breath          | <input type="checkbox"/> Wheezing   |
| <input type="checkbox"/> Chronic cough    | <input type="checkbox"/> Other                        |                                     |

#### Is patient on Statin

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

### Hypertension

#### Describe

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

#### Supported by

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Physical Exam | <input checked="" type="checkbox"/> <b>Medications</b> | <input type="checkbox"/> Symptoms            |
| <input type="checkbox"/> Chest pain    | <input type="checkbox"/> Light headedness              | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Wheezing      | <input type="checkbox"/> Chronic cough                 | <input type="checkbox"/> Other               |

#### Adequately controlled

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

## 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)

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

## Diagnoses

- |   |   |
|---|---|
| <input type="checkbox"/> Bowel Obstruction      | <input type="checkbox"/> Cachexia                   |
| <input type="checkbox"/> Celiac Disease         | <input type="checkbox"/> Cirrhosis                  |
| <input type="checkbox"/> Colon Polyps           | <input type="checkbox"/> Diverticulitis             |
| <input type="checkbox"/> Gall Bladder Disease   | <input type="checkbox"/> Gastroparesis              |
| <input checked="" type="checkbox"/> <b>GERD</b> | <input type="checkbox"/> GI Bleed                   |
| <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Inflammatory Bowel Disease |
| <input type="checkbox"/> Pancreatitis           | <input type="checkbox"/> Ulcer Disease              |
| <input type="checkbox"/> Other                  |   |

### GERD

- ↳ Describe
  - ☒ Active
- ↳ Supported by
  - ☒ Heartburn / Dyspepsia
  - ☐ Abdominal pain
- ☐ History of
- ☐ Regurgitation
- ☒ Nausea and vomiting
- ☐ Rule out
- ☒ Medications
- ☐ Other

## Recommendations

- ☒ Take medications as prescribed
- ☐ Other

## Bowel Movements

- ☐ Normal
- ☒ Abnormal
  - ↳ If abnormal
    - ☐ Constipation
    - ☒ Diarrhea
    - ☐ Bowel Incontinence
  - ↳ If Diarrhea
    - ☐ Acute
    - ☒ Chronic
  - ↳ If Diarrhea, history of C Difficile
    - ☐ Yes
    - ☒ No

## 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

- |  |   |
|--|---|
| <input type="checkbox"/> Alcohol Dependence    | <input type="checkbox"/> Amyotrophic Lateral Sclerosis                |
| <input checked="" type="checkbox"/> Anxiety    | <input type="checkbox"/> Bipolar Disorder                             |
| <input type="checkbox"/> Cerebral Hemorrhage   | <input type="checkbox"/> Cerebral Palsy                               |
| <input type="checkbox"/> Delusional Disease    | <input type="checkbox"/> Dementia                                     |
| <input checked="" type="checkbox"/> Depression | <input type="checkbox"/> Drug Dependence                              |
| <input type="checkbox"/> Fibromyalgia          | <input type="checkbox"/> Guillain-Barre Disease                       |
| <input type="checkbox"/> Hemiparesis           | <input type="checkbox"/> Huntington's Chorea                          |
| <input checked="" type="checkbox"/> Insomnia   | <input type="checkbox"/> Intellectual and or Developmental Disability |
| <input type="checkbox"/> Migraine Headaches    | <input type="checkbox"/> Multiple Sclerosis                           |
| <input type="checkbox"/> Muscular Dystrophy    | <input type="checkbox"/> Myasthenia Gravis                            |
| <input type="checkbox"/> Parkinson's disease   | <input type="checkbox"/> Peripheral Neuropathy                        |
| <input type="checkbox"/> Restless leg syndrome | <input type="checkbox"/> Schizophrenia                                |

- ☐ Seizures

☐ Stroke

☐ TIA

☒ Other

Anxiety

Describe

☒ Active

Type

☒ Generalized Anxiety Disorder

Supported by

☐ Symptoms

☐ Other

History of

☐ GAD 7

Rule out

☐ Obsessive-Compulsive Disorder

☐ Other

Antianxiety medication

☐ Spinal Cord Injury

☐ Subdural Hematoma

☐ Traumatic Brain Injury

☐ Post traumatic stress disorder

☐ Social Phobia

☐ Depression

Describe

☒ Active

Supported by

☒ Symptoms

☐ Other

Major

☐ Yes

Episodes

☐ Single

☒ Unknown

Insomnia

Describe

☒ Active

Supported by

☒ Medication

☐ Other

Other

Describe

☒ Active

Supported by

☐ History

☒ Medications

☐ Biopsy

Other

History of

☐ PHQ 2 / 9

Rule out

☒ Use of antidepressant medication

Unknown

☐ In Remission

History Of

☒ Symptoms

History

History of

☒ Symptoms

☐ Test results

☐ DME

Rule out

☐ Physical Findings

☐ Image studies

☐ Other

comments

Schizoaffective Disorder

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 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 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

☒ Flat

☐ Other

☐ Delusional

☐ Manic

☐ Disorganized thought

☐ Depressed

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

DEPRESSION SCREENING PHQ9

Having little interest or pleasure in doing things?

☒ Not at all

☐ Several

☐ More than half the days

☐ Nearly Every Day

Feeling down, depressed or hopeless at times?

☐ Not at all

☒ Several

☐ More than half the days

☐ Nearly Every Day

Do you have trouble falling or staying asleep, sleeping too much?

☐ Not at all

☒ Several

☐ More than half the days

☐ Nearly Every Day

Do you feeling tired or having little energy?

☒ Not at all

☐ Several

☐ More than half the days

☐ Nearly Every Day

Do you have a poor appetite or overeating?

☐ Not at all

☒ Several

☐ More than half the days

☐ Nearly Every Day

comments

attributes poor appetite to her GI problems

Feeling bad about yourself or that you are a failure or have let yourself or your family down?

☒ Not at all

☐ Several

☐ More than half the days

☐ Nearly Every Day

Trouble concentrating on things, such as reading the newspaper or watching TV?

☒ Not at all

☐ Several

☐ More than half the days

☐ Nearly Every Day

Moving or speaking so slowly that other people have noticed. Or opposite-being fidgety or restless that you have been moving around a lot more than usual?

☒ Not at all

☐ Several

☐ More than half the days

☐ Nearly Every Day

Thoughts that you would be better off dead, or hurting yourself?

☒ Not at all

☐ Several

☐ More than half the days

☐ Nearly Every Day

PHQ 9 Score

3

If Score is Greater than 15, recommend additional treatment

Score	Depression Severity
1 - 4	Minimal Depression
5 - 9	Mild Depression
10 - 14	Moderate Depression
15 - 19	Moderately Severe Depression
20 - 27	Severe Depression

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
- ☐ Abductor lurch
- ☐ Paretic
- ☐ Shuffling
- ☐ Ataxic
- ☐ 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)

- ☒ Yes
- ☐ No

Diagnoses

- ☐ Acute Renal Failure
- ☐ BPH
- ☐ Chronic Kidney Disease
- ☐ ESRD



- ☐ Erectile Dysfunction
- ☐ Gynecological
- ☐ Nephritis or Nephrosis
- ☐ Other

- ☐ Frequent UTI
- ☐ Kidney Stones
- ☒ **Urinary Incontinence**

### Urinary Incontinence

#### Describe

☒ **Active**

☐ History of

☐ Rule out

#### Supported by

- ☐ History
- ☐ Medications
- ☐ Other

- ☒ **Symptoms**
- ☐ Test results

- ☐ Physical Findings
- ☐ DME

#### Related to stress

☐ Yes

☒ **No**

#### Describe

☐ Daily

☐ Few times a week

☒ **Less than once a week**

### Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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

☒ **Yes**

☐ No

#### Diagnoses

- ☐ Collagen (Connective) Tissue Disease
- ☐ Degenerative Disc Disease
- ☐ Extremity Fracture
- ☐ Gout
- ☐ Hallux Valgus
- ☐ Hammer Toes
- ☒ **Osteoarthritis**
- ☐ Osteomyelitis
- ☐ Osteoporosis
- ☐ Pyogenic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Spinal Stenosis
- ☐ Systemic Lupus Erythematosus
- ☐ Other

### Osteoarthritis

#### Describe

☒ **Active**

☐ History of

☐ Rule out

#### Supported by

- ☒ **Symptoms**
- ☒ **Other**

☐ Physical Findings

☐ Image studies

### Symptoms

#### Describe

- ☐ Joint swelling
- ☐ Limited ROM

☐ Joint stiffness

☒ **Pain**

### Other

#### Describe

comments

history of left TKR

#### Which joints

comments

both knees, back

## Have you had an amputation?

☐ Yes ☒ No

## Recommendations

- ☐ Discuss PT/OT evaluation with PCP
- ☒ **Take medications as prescribed**
- ☐ Other

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

☐ Yes ☒ No

## 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 type="checkbox"/> Cushing's Disease                                 | <input checked="" type="checkbox"/> <b>Diabetes</b>                  |
| <input type="checkbox"/> Diabetic Retinopathy                              | <input type="checkbox"/> Secondary Hyperparathyroidism               |
| <input type="checkbox"/> Hypertension and Diabetes                         | <input type="checkbox"/> Hyperthyroidism                             |
| <input type="checkbox"/> Hypothyroidism                                    | <input type="checkbox"/> Peripheral Neuropathy secondary to Diabetes |
| <input type="checkbox"/> Peripheral Vascular Disease secondary to Diabetes | <input type="checkbox"/> Hyperparathyroidism                         |
| <input type="checkbox"/> Other   |  |

### Diabetes

#### Describe

☒ **Active** ☐ History of ☐ Rule out

#### Supported by

☐ Symptoms ☐ Physical findings ☐ Lab tests

☒ **Medications** ☐ Other

#### Type

☐ Type 1 ☐ Type 1.5 ☒ **Type 2**

☐ Gestational

#### Most recent Hb A1C, value

comments

does not know

#### And Date

comments

cant remeber

#### Met with a nurse or dietician for diabetic education

☐ Yes ☒ No

#### Met with a diabetic educator

☐ Yes ☒ No

#### Do you test your blood sugar

☐ Yes ☒ No

## Recommendations

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

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

- ☒ Yes
- ☐ No

### Diagnoses

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

comments

Sickle cell trait listed in previous conditions. She did not mention this

### Anemia

#### Describe

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

#### Supported by

- |  |   |   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>Lab tests</b> | <input checked="" type="checkbox"/> <b>Symptoms</b> | <input type="checkbox"/> History of blood transfusion |
|--|---|---|

- ☐ Other

#### Etiology

- |  |  |  |
|--|--|--|
| <input checked="" type="checkbox"/> <b>Iron deficiency</b> | <input type="checkbox"/> Pernicious      | <input type="checkbox"/> Kidney disease    |
| <input type="checkbox"/> Hemolysis                         | <input type="checkbox"/> Aplastic        | <input type="checkbox"/> Chemotherapy      |
| <input type="checkbox"/> Blood loss                        | <input type="checkbox"/> Chronic Disease | <input type="checkbox"/> Folate Deficiency |
| <input type="checkbox"/> Other                             |  |  |

#### If yes, Patient on

- |   |                                |                                     |
|---|--------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> <b>Iron</b> | <input type="checkbox"/> B 12  | <input type="checkbox"/> Folic Acid |
| <input type="checkbox"/> Blood Transfusions     | <input type="checkbox"/> Other |                                     |

### Vitamin D Deficiency

#### Describe

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

#### Supported by

- |   |                                      |                                  |
|---|--------------------------------------|----------------------------------|
| <input checked="" type="checkbox"/> <b>Labs</b> | <input type="checkbox"/> Medications | <input type="checkbox"/> History |
| <input type="checkbox"/> Other                  |                                      |                                  |

comments

used to take Vitamin D

## Recommendations

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

## Cancer

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

## Recommendations

- ☐ Take medications as prescribed
- ☐ Other

## Pain

Does the patient experience pain?

- ☒ Yes
- ☐ No

Is the Pain Acute?

- ☐ Yes
- ☒ No

Is the Pain Chronic?

- ☒ Yes
- ☐ No

Describe

☒ Active

☐ History of

☐ Rule out

Where

knees and back

Rate your pain on a scale of 1-10, with 1 being very mild and 10 being severe

8/10

Frequency of pain

- ☐ Occasional
- ☒ One or more times a week
- ☐ All of the time

comments relieved when smokes cannabis

Is the Patient Undergoing Pain Management Planning?

- ☐ Yes
- ☒ No

Is the member taking a narcotic or Opioid Medication?

- ☐ Yes
- ☒ No

Was the patient advised regarding the potential for dependence?

- ☒ Yes
- ☐ No

## Vital Signs

### Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
138 (mmHG)	80 (mmHG)	83 (bpm)	16	97.6	97	2/10

### BMI

Patients Height		Patients Weight	BMI
5 (Feet)	11 (Inch)	324 (lbs)	45.2

- ☐ Obesity
 ☐ Moderate Obesity
 ☒ **Morbid Obesity**
- ☐ Malnutrition

#### Are you on a special diet?

- ☐ Heart Healthy Diet
 ☐ Diabetic Diet
 ☐ Renal Diet
- ☐ Vegetarian
 ☐ Vegan
 ☐ Gluten Free
- ☐ Keto
 ☐ Pescatarian
 ☐ Other

comments

does not follow a special diet

#### Have you lost weight in the past 6 months?

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

comments

due to poor appetite and GI problems

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

Comment: limping gait

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

CN 2-12 grossly intact

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

Comment: flat affect

## 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)





f. Is your hot water heater set for a maximum of 120 degrees?	Yes	No
Comment: does not know		
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?**

no

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

relief from GI problems

**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 :


44 yo woman with psychiatric condition and chronic health diseases. Not a reliable historian. She is mostly concerned with her GI distress at this time, and has follow up with GI scheduled. She is mostly concerned that she did not receive her Healthy Rewards gift card.

Strongly advised to adhere to medication regimen as ordered by providers

### 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 :	2022-02-11T10:30
Time exam finished	2022-02-11T11:35

I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Provider Signature	<div>Cheryl Miller, GNP-BC</div> <div>Digitally signed by Cheryl Miller, NP 2022-02-16, 12:35</div>
Addendum	
Addendum Signature	

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).