

HRA Form

Health Plan :	Optima Health
Member Name :	ELIZABETH A HARLOW
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1966-01-01
Evaluation Date :	2022-10-3 11:00 AM
Visit Type :	In Person

Demographics

Plan	OHP
Program	MEDICARE
LOB	MA-Non DSNP
Name	ELIZABETH A HARLOW
Gender	Female
Address	3841 MAIDENS ROAD
City	POWHATAN
State	VA
Zip	23139-9998
Date of Birth	1966-01-01
Age(as of date)	56
Marital Status	Single
Member Identification Number	900043917*01
HICN	
Phone Number	804/720-3719
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	dave duffy
Phone Number	8046902477
Primary Care Physician	GEORGE, AMANDA MD
Phone Number	804/828-9357
PCP Address	417 N 11TH ST
PCP City	RICHMOND
PCP State	VA

PCP Zip	23298
PCP County	
Office ID	
Office Name	MCV ASSOCIATED PHYSICIANS

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

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

↳ When

- ☐ Stopped within the last year ☐ Stopped within the last 3 years ☒ **Stopped 5 or more years ago**

Type

☒ Cigarettes☐ Vaping☐ Cigars☐ Other☐ Chewing Tobacco

How Many

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

Alcohol Use

☐ Current☒ Former☐ Never

How many drinks	How Often
3	Month

Do you or have you used recreational drugs?

☒ Yes☐ No

Which drugs
THC

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

Where is it kept?
home

☐ 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

☒ Cane

☒ Oxygen

☐ Urinal

☐ Other

☐ Describe

☐ PRN

☐ Night

☐ Litres / Min
4

☐ Walker

☒ Wheel Chair

☐ Bed Pan

☐ Prosthesis

☒ Bedside Commode

☒ CPAP

☒ Continuous

☐ Day

Are you currently seeing any specialists?

☒ Yes

☐ No

Medical Specialty	Specialist	For
Pulmonologist	VCU	COPD, resp failure
Cardiologist	VCU	CAD, PVD
Other	vascular surgery VCU	PVD
Dermatologist	VCU	squamous cell carcinoma

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	None	1	2	3	4	5 or more

Room						
------	--	--	--	--	--	--

[If one or more, describe](#)

hip fx, hypercapnia, GI bleedx2

C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
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[If one or more, describe](#)

hip fx, hypercapnia, GI bleedx2

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

[If one or more, describe](#)

right hip fx surgery

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

☒ Yes

☐ No

[Describe](#)

MI with cath and stentsx2, 1 AAA stent, BLE stents, PE, COPD exacerbations,

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
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Family History

Family History

☒ Yes

☐ No

Family Member	Medical Condition	Cause of Death
Father	heart disease, CVA	
Mother	heart disease, CVA	

Preventive Care

In the past three years have you had?

Screen	Answer	Date	Method	Recommendation	Education Completed
Breast Cancer Screening	Yes	2020	mammogram	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Screening	Yes	2022		<input type="checkbox"/>	<input type="checkbox"/>
Influenza Vaccine	Yes	2021	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
COVID-19 Vaccine	Yes	2021	N/A	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal Vaccine	Yes	unknown	N/A	<input type="checkbox"/>	<input type="checkbox"/>
Herpes Zoster Vaccine	No		N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Diabetes Screening	Yes	2022	N/A	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Foot Exam	No		N/A	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol Screening	Yes	2022	N/A	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma Screening	No		N/A	<input type="checkbox"/>	<input type="checkbox"/>
STIs/HIV Screening	No		N/A	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer Screening	No		N/A	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis Screening	Yes	2022	dexa	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Screening	No		N/A	<input type="checkbox"/>	<input type="checkbox"/>
Fall Risk Screening	No		N/A	<input type="checkbox"/>	<input 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	
muscle spasms	CYCLOBENZAPR	TAB 10MG	PO = By Mouth	PRN	pcp	Taking	Not Taking
COPD	ALBUTEROL	AER HFA	IN = Inhalation	PRN	pulm	Taking	Not Taking
COPD	BENZONATE	CAP 100MG	PO = By Mouth	PRN	pulm	Taking	Not Taking
COPD	DALIRESP	TAB 250MCG	PO = By Mouth	QD	pulm	Taking	Not Taking
COPD	IPRATROPIUM	SOL 0.02%INH	IN = Inhalation	PRN	pulm	Taking	Not Taking
chronic bronchitis	AZITHROMYCIN	TAB 250MG	PO = By Mouth	QD	pulm	Taking	Not Taking
COPD	BUDESFORMOT	AER 160-4.5	IN = Inhalation	QD	pulm	Taking	Not Taking
COPD	PREDNISON	TAB 5MG	PO = By Mouth	QD	pulm	Taking	Not Taking
HTN	METOPROLOL	TAB 50MG	PO = By Mouth	QD	cards	Taking	Not Taking
HLD	ATORVASTATIN	TAB 80MG	PO = By Mouth	QD	cards	Taking	Not Taking
angina	NITROGLYCERIN	SUB 0.4MG	S = Sublingual	PRN	cards	Taking	Not Taking
COPD	GUAIAIATUSS	SYP 100-10/5	PO = By Mouth	PRN	pulm	Taking	Not Taking
CAD	CLOPIDOGREL	TAB 75MG	PO = By Mouth	QD	cards	Taking	Not Taking
COPD	LEVALBUTEROL	NEB 1.25MG	IN = Inhalation	PRN	pulm	Taking	Not Taking
GERD	PANTOPRAZOLE	TAB 40MG	PO = By Mouth	QD	pcp	Taking	Not Taking
osteoporosis	forteo	20mcg	SQ = Subcutaneous	QD	pcp	Taking	Not Taking
CAD	asa	81mg	PO = By Mouth	Select	cards	Taking	Not Taking

36. Over the Counter Medications / Supplements

☐ Yes ☒ No

Long Term Use of:

☐ None

☒ ASA

☒ Steroids

☐ Insulin

☒ Anticoagulants

☒ Statins

☐ Biphosphonate

☐ Describe

☐ Coumadin

☐ Thrombin Inhibitors ☒ Plavix
(Paradaxa)

☐ Factor Xa Inhibitors ☐ Other
(Xarelto, Eliquis)

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

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

☐ Yes ☒ No

Nose Problems (Nose Bleeds, Sinus infections, Other)

☐ Yes ☒ No

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

☒ Yes

☐ No

↳ Diagnoses

☐ Bleeding Gums

☐ Difficulty Chewing

☒ **Difficulty Swallowing**

☐ Other

Difficulty Swallowing

↳ Describe

☐ Active

☒ **History of**

☐ Rule out

↳ Have you had a stroke

☐ Yes

☒ **No**

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes

☒ **No**

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**

☐ Acute Upper Respiratory Infection

☐ Asthma

☐ Chronic Pulmonary Embolism

☒ **Chronic Respiratory Failure**

☐ Chronic Sputum Production

☒ **COPD**

☐ Cystic Fibrosis

☐ Hypoventilation secondary to Obesity

☒ **Hypoxemia**

☐ Pneumonia

☐ Pulmonary Fibrosis

☐ Respirator Dependence/
Tracheostomy Status

☒ **Respiratory Arrest**

☐ Sarcoidosis

☒ **Sleep Apnea**

☐ Other

Acute Pulmonary Embolism

↳ Describe

☐ Active (in past 6 months)

☒ **History of**

☐ Rule Out

↳ Supported by

☒ **Hospitalization for Pulmonary Embolism**

☐ CT Angiogram

☐ Venous Doppler

☐ D-dimer

☐ VQ scan

☒ **Use of anticoagulation**

☐ Shortness of breath

☐ Wheezing

☐ Chronic cough

☐ Other

Chronic Respiratory Failure

- Describe
 - ☒ Active
 - History of
 - Rule out
- Supported by
 - ☒ History of hospitalization with Respiratory Failure
 - Chronic use of O2 at >2L/min
 - CO2 Retention
 - ☐ Use of ventilator
 - ☐ Shortness of breath
 - ☐ Wheezing
 - ☐ Chronic cough
 - ☐ Other

COPD

- Describe
 - ☒ Active
 - History of
 - Rule out
- Supported by
 - ☐ Use of accessory muscles
 - ☒ Barrel Chest
 - ☐ XR results
 - ☐ Wheezing
 - ☐ Clubbing
 - ☐ Decreased or prolonged breath sounds
 - ☐ Dyspnea on exertion
 - ☒ O2 use
 - ☒ Bronchodilator medication
 - ☐ Shortness of breath
 - ☐ Chronic cough
 - ☐ Other
- Has patient been told they have Chronic Bronchitis
 - ☒ Yes
 - ☐ No
- Has patient been told they have Emphysema
 - ☒ Yes
 - ☐ No
- Is patient on Bronchodilator
 - ☒ Yes
 - ☐ No
- Route is
 - ☒ Inhaled
 - ☐ Nebulizer
 - ☐ Oral
- Is patient on Steroids
 - ☒ Yes
 - ☐ No
- Route is
 - ☒ Inhaled
 - ☐ Nebulizer
 - ☐ Oral
- Does patient have current exacerbation
 - ☐ Yes
 - ☒ No

Hypoxemia

- Describe
 - ☒ Active
 - History of
 - Rule out
- Supported by
 - ☐ O2 saturation of <90% on room air
 - ☒ Shortness of breath
 - ☐ Wheezing
 - ☒ Chronic cough
 - ☐ Other

Respiratory Arrest

- Describe
 - ☐ Active (in past 3 months)
 - ☒ History of
 - ☐ Rule out
- Supported by

- ## Sleep Apnea

Supported by

- Take medications as prescribed
- Other

☒ Yes ☐ No

- Abnormal Cardiac Rhythm
- **Angina**
- Cardio – Respiratory Failure / Shock
- Congestive Heart Failure
- **Hyperlipidemia**
- **Ischemic Heart Disease (CAD)**
- **Peripheral Vascular Disease**
- Valvular Disease

Supported by

- ## Describe

Angina

Active

- ## History of

- Thoracic

- ## History Of

- ☒ **Aneurysm**
- ☐ Atrial Fibrillation
- ☐ Cardiomyopathy
- ☐ Deep Vein Thrombosis
- ☒ **Hypertension**
- ☒ **Myocardial Infarction**
- ☐ Pulmonary Hypertension
- ☐ Other

- Rule out

- ## Image studies

- Shortness of breath
- Other

- ## Peripheral

- Rule out

Medications

Chest pain

Wheezing

Describe

Stable

Hyperlipidemia

Describe

Active

Supported by

Lab results

Light headedness

Chronic cough

Is patient on Statin

Yes

Hypertension

Describe

Active

Supported by

Physical Exam

Chest pain

Wheezing

Adequately controlled

Yes

Ischemic Heart Disease (CAD)

Describe

Active

Supported by

Cardiac Cath

Medications

Chest pain

Wheezing

Myocardial Infarction

Describe

Active (in past 28 days)

History of

Date

History

characterizing chest pain

Light headedness

Chronic cough

Unstable

History of

Medication

Shortness of breath

Other

No

History of

Medications

Light headedness

Chronic cough

No

History of coronary

stent

History of CABG

Light headedness

Chronic cough

Diagnosis of angina

stent

ECG

Shortness of breath

Other

Stress test

Shortness of breath

Other

Rule out

Chest pain

Wheezing

Rule out

Symptoms

Shortness of breath

Other

Rule out

UnKnown

Rule out

Rule out

Rule out

Rule out

comments

2010

Supported by

ECG changes

Lab results

History of Hospitalization / Procedure for MI

Medications

Chest pain


Light headedness

Shortness of breath

Wheezing

Chronic cough

Other



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Is patient taking a Beta Blocker

☒ Yes ☐ No

Is patient taking

☒ Aspirin ☐ Plavix ☐ Nitrate
☐ Other

comments

and plavix and nitro

Peripheral Vascular Disease

Describe

☒ Active ☐ History of ☐ Rule out

Supported by

☒ Vascular studies ☒ Claudication ☐ Extremity Ulcers
☐ Diminished or absent pulses ☐ Amputation ☐ Chest pain
☐ Light headedness ☐ Shortness of breath ☐ Wheezing
☐ Chronic cough ☒ Other

Other

Describe

comments

meds

History Diabetes

☐ Yes ☒ No

Describe

☐ Ulceration ☐ Gangrene

comments

NA

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

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"/> GERD	<input checked="" type="checkbox"/> GI Bleed
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Inflammatory Bowel Disease
<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Ulcer Disease
<input checked="" type="checkbox"/> Other	

GERD

Describe

☒ Active ☐ History of ☐ Rule out

Supported by

☐ Heartburn / Dyspepsia ☐ Regurgitation ☒ Medications

☐ Abdominal pain

☐ Nausea and vomiting

☐ Other

GI Bleed

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☐ Symptoms

☒ Blood in stool

☐ Abdominal pain

☐ Nausea and vomiting

☐ Other

Other

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☒ History

☐ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Abdominal pain

☐ Nausea and vomiting

☐ Other

Other

comments

fatty liver disease, stable

Recommendations

☒ Take medications as prescribed

☐ Other

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

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

☒ Yes

☐ No

comments

feel stressed on

Do you worry too much about different things?

☒ Yes

☐ No

comments

differen on

Do you feel afraid that something bad might happen?

☒ Yes

☐ No

comments

some hing happened

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

Finger to Nose

☒ Normal

☐ Abnormal

Heel (Shin) to Toe

☒ Normal

☐ Abnormal

Thumb to Finger Tips

☒ Normal

☐ Abnormal

Sitting to Standing

☒ Normal

☐ Needs Assistance

☐ Unable

Facial / Extremity Movement

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

Gait

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

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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

- ☐ Yes
- ☒ **No**

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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

- ☒ **Yes**
- ☐ No

Diagnoses

- ☐ Collagen (Connective) Tissue Disease

☐ Extremity Fracture

☐ Hallux Valgus

☐ Osteoarthritis

☒ **Osteoporosis**

☐ Rheumatoid Arthritis

☐ Systemic Lupus Erythematosus
- ☐ Degenerative Disc Disease

☐ Gout

☐ Hammer Toes

☐ Osteomyelitis

☐ Pyogenic Arthritis

☐ Spinal Stenosis

☒ **Other**

Osteoporosis

Describe

- ☒ **Active**

Supported by

- ☒ **Dexa scan**
- ☐ Symptoms

Other

Describe

- ☒ **Active**

Supported by

- ☐ History of

☐ Rule out
- ☒ **Medications**

☐ Imaging studies
- ☐ Fracture history

☐ Other
- ☐ History of

☐ Rule out

- ☐ History

☒ Medications

☐ Biopsy

☐ Other
- ☐ Symptoms

☐ Test results

☐ DME
- ☐ Physical Findings

☐ Image studies

☐ Other

comments

muscle spasms

Have you had an amputation?

- ☒ Yes
- ☐ No

comments

amputations

☐ Describe

described

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

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
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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

bilateral legs

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

8

Frequency of pain

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

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
110 (mmHG)	60 (mmHG)	90 (bpm)	20	98.6	98	0

BMI

Patients Height		Patients Weight	BMI
5 (Feet)	3 (Inch)	109 (lbs)	19.3

☐ 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

Describe reg

Have you lost weight in the past 6 months?

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

Recommendations

- ☐ Nutrition/ weight management
☐ Other

Exam Review

Constitutional

General appearance:	Normal	Abnormal
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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

Comment: decreased lung sounds throughout

Cardiovascular

Auscultation of heart:	Normal	Abnormal
Palpation and auscultation of Carotid Arteries:	Normal	Abnormal

Comment: bilateral bruits

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
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Neurologic

Indicate specific cranial nerve tested

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
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Comment: NA

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 : 1

Person's Answers: banana, sunrise

Word Recall :	2 Points	1 point for each word spontaneously recalled without cueing. Home Safety Yes
Clock Draw :	2 Points	Normal clock = 2 points. A normal clock has all numbers placed in the correct positions) with no missing or duplicate numbers. Hands are pointing to the 11 sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor Inability or refusal to draw a clock (abnormal) = 0 points.and 2 (11:10). Hand length is not scored.
Total Score :	4 Points	Total score = Word Recall score + Clock Draw score. A cut point of < 3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of < 4 is recommended as it may indicate a need for further evaluation of cognitive status.

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

Do you worry about falling or feeling unsteady when standing or walking

- ☒ Yes
- ☐ No

Worries about falling or feeling unsteady when standing or walking?

- ☒ Yes
- ☐ No

Did you have a fracture in past 6 months?

- ☒ Yes
- ☐ No

Was it due to fall?

- ☒ Yes
- ☐ No

Are you on osteoporosis med?

- ☒ Yes
- ☐ No

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?

none noted

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

none noted

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 in stable condition without any questions or concerns at this time, to follow up with PCP for any questions or changes.

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 :	2022-10-03T11:00
Time exam finished	2022-10-03T11:45
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Provider Signature	

	<div>David Cox</div> <div>Digitally signed by David Cox, Adult NP 2022-10-03, 21:16</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).