

HRA Form

Health Plan :	Tx
Member Name :	Calvin Adkins
Evaluator Name :	Shannon Lewallen, NP
Assessment Type :	Health Risk Assessment
DOB :	1933-09-18
Evaluation Date :	2021-7-14 04:45 PM
Visit Type :	In Person

Demographics

Plan	Tx
Program	PROGRAM
LOB	LOB
Name	Calvin Adkins
Gender	Female
Address	
City	
State	
Zip	
Date of Birth	1933-09-18
Age(as of date)	88
Marital Status	Separated
Member Identification Number	473861301
HICN	
Phone Number	
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	
Phone Number	
Primary Care Physician	
Phone Number	
PCP Address	
PCP City	
PCP State	

PCP Zip	
PCP County	
Office ID	
Office Name	

1. Race

- | | | |
|-----------------------------------------|-------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> African American | <input checked="" 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 type="checkbox"/> Prefer not to say | | |

2. Preferred language

- | | | |
|-------------------------------------------------|---------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> English | <input checked="" type="checkbox"/> Other | |
| ↳ If other, | | |
| <input type="checkbox"/> African languages | <input checked="" type="checkbox"/> Arabic | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> French | <input type="checkbox"/> French Creole | <input type="checkbox"/> German |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Gujarati | <input type="checkbox"/> Hebrew |
| <input type="checkbox"/> Hindi | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Italian |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Persian |
| <input type="checkbox"/> Polish | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Scandinavian Languages | <input type="checkbox"/> Serbo-Croatian | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Urdu | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Yiddish | | |

Previously Documented Conditions

Covid Screening

In the last 14 days, have you:

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

Developed Cough?	Yes	No
Developed Flu like symptoms?	Yes	No
Developed Shortness of breath?	Yes	No

Self-Assessment and Social History

3. How much school have you completed?

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

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

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

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

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

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

- ☐ Not at All Confident
 ☐ Not Very Confident
 ☐ Confident
 ☐ Very Confident

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

- ☐ Excellent
 ☐ Good
 ☐ Fair
 ☐ Poor

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

- ☐ Often
 ☐ Sometimes
 ☐ Almost Never
 ☐ Never

9. Where do you currently live?

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

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

- ☐ Yes
 ☐ No

11. Who do you currently live with?

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

12. Are you currently a caregiver for someone?

- ☐ Yes
 ☐ No

13. Tobacco use

- ☒ Current
 ☐ Former
 ☐ Never

Type

☐ Cigarettes

☐ Vaping

☐ Cigars

☐ Other

☐ Chewing Tobacco

14. Alcohol Use

☐ Current

☒ Former

☐ Never

How many drinks	How Often
Select	Select

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

☒ Yes

☐ No

Which drugs or medication

16. Do you have a Healthcare Proxy?

☐ Yes

☐ No

☐ Don't Know

17. Do you have a Durable Power of Attorney?

☒ Yes

☐ No

☐ Don't Know

Name

Relationship

18. 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

Activities of Daily Living

19. Do you have any difficulty with the following activities?

A. Getting in or out of bed	No	Need Some Help	Need Total Help
B. Getting in or out of chairs	No	Need Some Help	Need Total Help
C. Toileting	No	Need Some Help	Need Total Help
D. Bathing	No	Need Some Help	Need Total Help
E. Dressing	No	Need Some Help	Need Total Help
F. Eating	No	Need Some Help	Need Total Help
G. Walking	No	Need Some Help	Need Total Help

How far can you walk

H. Going up or down stairs	No	Need Some Help	Need Total Help
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↳ How many stairs can you climb

Medical History

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

☐ None

☒ Cane

☐ Wheel Chair

☐ Bed Pan

☒ Walker

☐ Bedside Commode

☐ Other

☐ Prosthesis

☐ Urinal

21. Are you currently seeing any specialists?

☒ Yes

☐ No

Medical Specialty	Specialist	For
Psychologist		

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

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

↳ If one or more, describe

C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
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↳ If one or more, describe

D. Been in a nursing home	None	1	2	3	4	5 or more
E. Had Surgery	None	1	2	3	4	5 or more

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

☒ Yes

☐ No

↳ Describe

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

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

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

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

Family History

26. Family History

☒ Yes

☐ No

Family Member	Medical Condition	Cause of Death
Father		

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	Yes
Breast Exam/Mammography	select
Cervical Screening	select
Bone Density	select
Prostate Exam/PSA	select
If Diabetic Eye Exam	select
If Diabetic Foot Exam	select
If Diabetic Hgb A1c screen	select
Lipid Panel	select

28. Last colonoscopy if more than 2 years ago

- ☐ 3 – 5 years ago
 ☐ 6 – 10 years ago
 ☐ > 10 years ago
☐ Never
 ☐ Don't know

29. Screen for abnormal glucose / diabetes - age 40 - 70

- ☐ Yes
 ☐ No
 ☐ NA

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

- ☐ Yes
 ☐ No
 ☐ NA

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

- ☐ Yes
 ☐ No
 ☐ NA

32. Do you get Flu Vaccine each year?

- ☐ Yes
 ☐ No

33. Have you been vaccinated for Pneumonia?

- ☐ Yes
 ☐ No

34. Have you been vaccinated for Herpes Zoster?

- ☒ Yes
 ☐ No
 ↳ Zostervax
 ☐ Yes
 ☐ No
 ☐ Unknown
 ↳ Shingrex
 ☐ Yes
 ☐ No
 ☐ Unknown

Allergies / Medications

35. Allergies

- ☒ Yes
 ☐ No

Substance	Reaction

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
hypertension	lisinopril		PO = By Mouth	QD		Taking	Not Taking

36. Over the Counter Medications / Supplements

- ☒ Yes
 ☐ No

Date	Description	Dose/Units	Route	Frequency
12-30-2021				

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37. Chronic Use of

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

38. Medication Compliance and Knowledge of Use and Disease

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

Review of Systems and Diagnoses

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

- ☒ **Yes**
☐ No
- ↳ Diagnoses
- ☒ **Cataracts**
 - ☐ Glaucoma
 - ☐ Macular Degeneration
 - ☐ Retinal Disease
 - ☐ Difficulty with vision
 - ☐ Hyperopia
 - ☐ Myopia
 - ☐ Others
- Cataracts**
- ↳ 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

Do you wear glasses or contacts?

- ☒ **Yes**
☐ No

↳ Do you have trouble seeing even with glasses?

- ☐ Yes
 ☐ No

Do you have problems seeing at night?

- ☐ Yes
 ☐ No

Do you have eye pain?

- ☐ Yes
 ☐ No

Do you have problems with tearing?

☐ Yes ☐ No

Do you have a problem with dry eye?

☐ Yes ☐ No

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

☒ Yes ☐ No

↳ Diagnoses

☐ Difficulty with Hearing

☐ Legally Deaf

☒ Tinnitus

☐ Vertigo

☐ Other

Tinnitus

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☒ History

☒ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Do you have trouble hearing when people talk to you?

☐ Yes ☐ No

Do you wear a hearing aid?

☐ Yes ☐ No

Do you read lips?

☐ Yes ☐ No

Do you have ear pain or drainage?

☐ Yes ☐ No

Do you ever get dizzy?

☐ Yes ☐ No

Nose Problems (Nose Bleeds, Sinus infections, Other)

☒ Yes ☐ No

↳ Diagnoses

☐ Chronic Post Nasal Drip

☐ Nose Bleeds

☐ Sinus Infections

☒ Other

Other

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☒ History

☒ Symptoms

☐ Physical Findings

☒ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

↳ Other

comments

allergic rhinitis

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

☐ Yes ☒ No

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☒ Yes

☐ No

Diagnoses

☒ **Carotid Stenosis**

☐ Parotid Disease

☐ Other

Carotid Stenosis

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☐ Bruits

☐ History of TIAs

☐ Laboratory studies

☐ Other

Describe

☐ Right

☐ Left

☐ Bilateral

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

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

☒ **Brinchodilator
medication**

☐ Respirator

☐ 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**

☒ **Does patient have current exacerbation**
☒ **Yes**
☐ No

Use of Oxygen
☒ **Yes**
☐ No

☒ **Describe**
☐ PRN
 ☐ Continuous
 ☐ Day

☐ Night

☒ **Litres / Min**

Shortness of breath
☐ Yes
 ☐ No

Wheezing
☐ Yes
 ☐ No

Chronic Cough
☐ Yes
 ☐ No

Patient requires durable medical equipment
☒ **Yes**
☐ No

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 type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Ischemic Heart Disease (CAD)	<input checked="" type="checkbox"/> Myocardial Infarction
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Pulmonary Hypertension
<input type="checkbox"/> Valvular Disease	<input type="checkbox"/> Other

☒ **Myocardial Infarction**

☒ **Describe**

☐ Active (in past 28 days)
 ☒ **History of**
☐ Rule out

☒ **Supported by**

☐ ECG changes
 ☐ Lab results
 ☒ **History of Hospitalization / Procedure for MI**

☒ **Medications**
☐ Other

☒ **Is patient taking a Beta Blocker**
☒ **Yes**
☐ No

☒ **Is patient taking**
☒ **Aspirin**
☐ Plavix
 ☐ Nitrate

☐ Other

History of Chest Pain

☐ Yes ☐ No

History of Intermittent Claudication

☐ Yes ☐ No

Implanted Pacemaker

☒ Yes ☐ No

☐ Describe

☐ Ventricular
Tachycardia

☐ Asystole

☐ Cardiac Arrest

☐ Last interrogation date

☐ Type and ID number

Implanted Defibrillator

☐ Yes ☐ No

Do you have abnormal heart beats?

☐ Yes ☐ No

Does your heart race?

☐ Yes ☐ No

Do you sleep on more than one pillow?

☐ Yes ☐ No

have you ever have fluid in your lungs?

☐ Yes ☐ No

Do your legs or ankles swell up?

☐ Yes ☐ No

Do you follow a special diet?

☐ Yes ☐ No

Do you have headaches?

☐ Yes ☐ No

Do you feel light headed when you stand up?

☐ Yes ☐ No

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

☒ Yes ☐ No

☐ Diagnoses

☐ Bowel Obstruction

☐ Celiac Disease

☐ Colon Polyps

☐ Gall Bladder Disease

☐ GERD

☐ Inflammatory Bowel Disease

☐ Ulcer Disease

☐ Cachexia

☐ Cirrhosis

☐ Diverticulitis

☐ Gastroparesis

☐ Hepatitis

☐ Pancreatitis

☐ Other

History of blood in stool

☐ Yes ☐ No

History of black stools

☐ Yes ☐ No

History of Heartburn / Dyspepsia

☐ Yes ☐ No

History of Vomiting or Regurgitation

☐ Yes ☐ No

History of pain after eating

☐ Yes ☐ No

History of Jaundice

☐ Yes ☐ No

Do you follow a special diet?

☐ Yes ☐ No

Do you have frequent abnormal abdominal pain?

☐ Yes ☐ No

Do you have intermittent nausea or vomiting?

☐ Yes ☐ No

Do you have trouble with constipation?

☐ Yes ☐ No

Does diarrhea limit your ability to get out of the room or socially?

☐ Yes ☐ No

Do you see blood in your urine?

☐ Yes ☐ No

Do you have Frequent Stomach Pain

☐ Yes ☐ No

Bowel Movements

☐ Normal ☒ **Abnormal**

↳ If abnormal

☒ **Constipation**

☐ Diarrhea

☐ Bowel Incontinence

Abdominal Openings

☒ **Yes** ☐ No

↳ Describe

☐ Ileostomy

☐ Colostomy

☐ Urostomy

☐ PEG

☐ Cystostomy

Rectal Problems

☒ **Yes** ☐ No

↳ If yes, female

☒ **Hemorrhoids**

☐ Fissure

☐ Mass

↳ If yes, male

☐ Hemorrhoids

☐ Fissure

☐ Mass

☐ BPH

☐ Prostate mass

Last Bowel Movement

☐ Today ☐ 1-3 days ago ☐ >3 days ago

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

☒ **Yes** ☐ No

↳ Diagnoses

☐ Alcohol Dependence

☐ Amyotrophic Lateral Sclerosis

- ☐ Bipolar Disorder
- ☐ Cerebral Palsy
- ☐ Dementia
- ☐ Drug Dependence
- ☐ Generalized Anxiety Disorder
- ☐ Hemiparesis
- ☐ Insomnia
- ☐ Migraine Headaches
- ☐ Muscular Dystrophy
- ☐ Parkinson's disease
- ☐ Restless leg syndrome
- ☐ Seizure Disorder
- ☒ **Stroke**
- ☐ TIA
- ☐ Other
- ☐ Cerebral Hemorrhage
- ☐ Delusional Disease
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Guillain-Barre Disease
- ☐ Huntington's Chorea
- ☐ Intellectual and or Developmental Disability
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Peripheral Neuropathy
- ☐ Schizophrenia
- ☐ Spinal Cord Injury
- ☐ Subdural Hematoma
- ☐ Traumatic Brain Injury

Stroke

Describe

☐ Active

☒ **History of**

☐ Rule out

Supported by

☒ **Hospitalization**

☐ Image study

☒ **Physical findings**

☐ Sensory findings

☐ Other

Physical findings

Physical findings

☐ None

☐ Right arm paralysis

☐ Left arm paralysis

☐ Right leg paralysis

☐ Left leg paralysis

☐ Right hemiparesis

☒ **Left hemiparesis**

☐ Apraxia

☐ Cranial nerve paralysis

☐ Functional Quadriplegia

comments

hx CVA in 2019, left hemiparesis is ongoing

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

- ☐ Yes
- ☐ No

Do you worry too much about different things?

- ☐ Yes
- ☐ No

Do you feel afraid that something bad might happen?

- ☐ Yes
- ☐ No

History of headaches

- ☐ Yes
- ☐ No

History of auditory hallucinations

- ☐ Yes
- ☐ No

History of visual hallucinations

- ☐ Yes
- ☐ No

History of psychotic behavior

- ☐ Yes
- ☐ No

History of episodes of delirium

- ☐ Yes
- ☐ No

Do you follow a special diet?

☐ Yes
☐ No

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

☐ Yes
☐ No

Do you have trouble swallowing your food?

☐ Yes
☐ No

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

☐ Yes
☐ No

Do you trouble understanding what people say to you?

☐ Yes
☐ No

Do your hands shake?

☐ Yes
☐ No

Do you have convulsions and seizures?

☐ Yes
☐ No

Do you have trouble with your memory?

☐ Yes
☐ No

Do you have trouble finding words?

☐ Yes
☐ No

Do you have trouble sleeping?

☐ Yes
☐ No

Have you lost your appetite

☐ Yes
☐ No

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

☐ Yes
☐ No

Do you have highs and lows

☐ Yes
☐ No

Do you ever feel like someone is out to get you

☐ Yes
☐ No

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

☐ Often
☐ Sometimes
☐ Never

GPCOG Score or MMSE Score

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

If GPCOG or MMSE is not done, is

☐ Patient oriented to person

☐ Yes
☐ No

☐ Patient oriented to place

☐ Yes
☐ No

☐ Patient oriented to time

☐ Yes
☐ No

☐ Recall

☐ Good
☐ Poor

☐ Patient describes recent news event

☐ Yes
☐ Partially
☐ No

Affect

☒ Normal

☐ Abnormal

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

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

PHQ 2 Score

☐ < 3

☒ 3 or more

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

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

Speech

- ☐ Normal
☐ Apraxia

☐ Slurred

☐ Aphasic

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)

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

☒ Yes

☐ No

Diagnoses

☐ Acute Renal Failure

☐ BPH

☒ Chronic Kidney Disease

☐ ESRD

☐ Erectile Dysfunction

☐ Frequent UTI

☐ Kidney Stones

☐ Nephritis or Nephrosis

☐ Urinary Incontinence

☐ Other

Chronic Kidney Disease

Describe

☒ Active

☐ History of

☐ Rule out

- ↳ **Supported by**
 - ☐ Lab tests
 - ☐ Calculated GFR X 3
 - ☐ Other
- ↳ **What stage**
 - ☐ 1 [GFR > 89]
 - ☐ 2 [GFR 60-89]
 - ☐ 3 [GFR 30-59]
 - ☐ 4 [GFR 15-29]
 - ☐ 5 [GFR <15]
- ↳ **Secondary to Diabetes**
 - ☐ Yes
 - ☐ No
- ↳ **Secondary to Hypertension**
 - ☐ Yes
 - ☐ No

History of frequency

☒ **Yes** ☐ No



- ☐ 3x / day
- ☐ 4x / day
- ☐ 5x / day
- ☐ >5x / day

History of Nocturia

☒ **Yes** ☐ No



- ☐ 1x / night
- ☐ 2x / night
- ☐ 3x / night
- ☐ >=4x / night

History of Hesitancy

☐ Yes ☐ No

Do you have trouble urinating?

☐ Yes ☐ No

Do you ever have blood in your urine?

☐ Yes ☐ No

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

☐ Yes ☐ No

Do you have trouble holding your urine?

☐ Yes ☐ No

Do you trouble getting to the bathroom on time?

☐ Yes ☐ No

Do you ever have pain or burning during urination?

☐ Yes ☐ No

Do you ever wear pads or diapers?

☐ Yes ☐ No

Do you have a vaginal discharge?

☐ Yes ☐ No

Do you have vaginal bleeding?

☐ Yes ☐ No

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

☒ **Yes** ☐ No



- ☐ Collagen (Connective) Tissue Disease
- ☐ Degenerative Disc Disease

- | | |
|--------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Extremity Fracture (other than Hip) | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Hallux Valgus | <input type="checkbox"/> Hammer Toes |
| <input type="checkbox"/> Onychomycosis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Pyogenic Arthritis | <input checked="" type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Spinal Stenosis | <input type="checkbox"/> Systemic Lupus Erythematosus |
| <input type="checkbox"/> Tinea Pedis | <input type="checkbox"/> Other |

Rheumatoid Arthritis

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☒ **Symptoms**

☐ Physical findings

☐ Lab tests

☐ Image Studies

☐ Other

Which joints

comments

Hips and knees- pain and swelling

History / Finding of non- extremity Fracture

☐ Yes

☐ No

History / Finding of Hip Fracture / Dislocation

☐ Yes

☐ No

History / Finding of Vertebral Fracture

☐ Yes

☐ No

Do you have any swelling of your joints?

☐ Yes

☐ No

Do you experience stiffness in the morning or during the day?

☐ Yes

☐ No

Do you have pain in your joints?

☒ **Yes**

☐ No

comments

knee pain due to RA

Do you have a problem straightening any joints?

☐ Yes

☐ No

Does pain and or swelling in your joints limit your activities?

☐ Yes

☐ No

Have you broken bones(fractures) in any parts of your body?

☐ Yes

☐ No

Do you have constant pain in your bones?

☐ Yes

☐ No

Have you had an amputation?

☐ Yes

☐ No

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

☒ **Yes**

☐ No

Diagnoses

☐ Basil Cell Carcinoma

☐ Dermatitis

☐ Eczema

☐ Psoriasis

☒ **Skin ulcer**

☐ Urticarial Disease

☐ Wound

☐ Other

Skin ulcer

- ↳ Describe
 - ☒ **Active**
- ↳ Supported by
 - ☐ History
 - ☐ Medications
 - ☐ Biopsy
- ↳ Etiology
 - ☒ **Pressure**
 - ☐ Disease Induced
- ☐ History of
- ☐ Rule out
- ☒ **Symptoms**
- ☐ Test results
- ☐ DME
- ☒ **Physical Findings**
- ☐ Image studies
- ☐ Other
- ☐ Venous Stasis
- ☐ Diabetic Vasculitis
- ☐ Peripheral Vascular Disease
- ☐ Diabetic Neuropathy

Do you have ulcers or wounds that require dressings?

- ☐ Yes ☐ No

Do you have a chronic skin condition?

- ☐ Yes ☐ No

Does your skin problem require the use of chronic medication, cream or ointment?

- ☐ Yes ☐ No

Do you get pains in your legs when you walk that make you stop to get relief?

- ☐ Yes ☐ No

Do you have skin breakdown or ulcers around your ankles?

- ☐ Yes ☐ No

Endocrine Problems

- ☒ **Yes** ☐ No

↳ Diagnoses

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

Diabetes

↳ Describe

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

↳ Supported by

- ☒ **Symptoms**
- ☒ **Medications**
- ☐ Physical findings
- ☐ Other
- ☐ Lab tests

↳ Type

- ☐ Type 1
- ☒ **Type 2**
- ☐ Gestational

↳ Most recent Hb A1C, value

↳ And Date

↳ Met with a nurse or dietician for diabetic education

- ☐ Yes ☐ No

↳ Met with a diabetic educator

- ☐ Yes ☐ No

Peripheral Neuropathy secondary to Diabetes

Describe

☐ Active ☐ History of ☐ Rule out

Supported by

☐ Physical exam ☐ Skin lesions ☐ Foot deformity
☐ Surgical procedures ☐ Other

Patient sees Podiatrist

☐ Yes ☐ No

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

☐ Yes ☐ No

Do you often feel thirsty?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Do you get ulcers on your legs or feet?

☐ Yes ☐ No

Do you feel sluggish?

☐ Yes ☐ No

Do you sweat a lot or constantly feel hot?

☐ Yes ☐ No

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

☐ Yes ☐ No

Have you ever had dialysis?

☐ Yes ☐ No

Is your skin itchy?

☐ Yes ☐ No

Do you test your blood sugar?

☒ Yes ☐ No

Have you lost weight in the past 6 months?

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

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

☒ Yes ☐ No

Diagnoses

☐ AIDS ☒ Anemia
☐ C. Difficile ☐ Community Acquired MRSA Infection
☐ HIV ☐ Herpes Zoster
☐ Hospital Acquired MRSA Infection ☐ Immune Deficiency
☐ Leukemia ☐ Lymphoma
☐ Multiple Myeloma ☐ Sepsis

☐ Sickle Cell Disease

☐ Thalassemia

☐ Tuberculosis

☐ Other

Anemia

Describe

☒ Active

Supported by

☒ Lab tests

Other

Etiology

☒ Iron deficiency

☐ Hemolysis

☐ Blood loss

☐ Other

If yes, Patient on

☒ Iron

☐ Blood Transfusions

☐ Sickle Cell Trait

☐ Thrombocytopenia

☐ Vitamin D Deficiency

☐ History of

☒ Symptoms

☐ Rule out

☐ History of blood transfusion

☐ Kidney disease

☐ Chemotherapy

☐ Folate Deficiency

☐ B 12

☐ Other

☐ Folic Acid

Easy bruising or abnormal bleeding

☐ Yes

☐ No

Long term anticoagulation use

☐ Yes

☐ No

Cancer

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

Describe

☐ Active

Supported by

☐ Physical findings

☐ Lab tests

☐ Biopsy

Type

☐ Brain

☐ Breast

☐ Stomach

☐ Colon

☐ Bladder

☐ Prostate

☐ Lymph Nodes

Specific type/s

Stage or Classification specific to the cancer

☐ History of

☐ Hospitalization

☐ Imaging studies

☐ Other

☐ Head

☐ Lung

☐ Liver

☐ Rectum

☐ Ovaries

☐ Bone

☐ Skin

☐ Rule out

☐ Treatments

☐ Surgery

☐ Neck

☐ Esophagus

☐ Pancreas

☐ Kidney

☐ Uterus

☐ Blood

☐ Other

Active treatment

☐ Yes ☐ No
History / Finding of Metastasis
☐ Yes ☐ No
Do you see a specialist?
☐ Yes ☐ No

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**
 ↳ **Do you take Methadone**
 ☐ Yes ☐ No
 ↳ **What drug/s do you take for it**
 ↳ **How bad is your pain on a scale of one to ten with one being very mild and ten being severe**
Is the Patient Undergoing Pain Management Planning?
☐ Yes ☐ No
Was the patient advised regarding the potential for dependence?
☐ Yes ☐ No
Is there any evidence of Maladaptive Behavior?
Tolerance?
☐ Yes ☐ No
Withdrawal?
☐ Yes ☐ No
Increased usage over a longer period that intended?
☐ Yes ☐ No
Desire or unsuccessful effort to cut down on use?
☐ Yes ☐ No
Excess time spent in activities to obtain the substance?
☐ Yes ☐ No
Continued use despite Doctor advice or patient knowledge of habituation?
☐ Yes ☐ No
Physical or Psychological Problem related to the substance use?
☐ Yes ☐ No

Vital Signs

Vital Signs

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

BMI

Patients Height		Patients Weight	Calculate BMI
(Feet)	(Inch)	(lbs)	

- ☐ Obesity (BMI 30 – 34.9)
 ☐ Moderate Obesity (BMI 35 – 39.9)
 ☐ Morbid Obesity (BMI = or > 40)
- ☐ Malnutrition (BMI < 18.5)

Exam Review

Constitutional

General appearance:	Normal	Abnormal
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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
Percussion of chest:	Normal	Abnormal

Palpation of chest:	Normal	Abnormal
Auscultation of lungs:	Normal	Abnormal

Cardiovascular

Palpation of heart:	Normal	Abnormal
Auscultation of heart:	Normal	Abnormal
Carotid Arteries:	Normal	Abnormal
Abdominal Aorta:	Normal	Abnormal
Pedal Pulses:	Normal	Abnormal
Examination of Arterial Pulses:	Normal	Abnormal
Examination of Edema / Varicosities:	Normal	Abnormal

Lymphatic

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

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
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
Palpation 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
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Psychiatric

Description of patient's judgement / insight:	Normal	Abnormal
Orientation of person, place and time:	Normal	Abnormal
Recent and remote memory:	Normal	Abnormal
Mood and affect:	Normal	Abnormal

Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnoses	Comments
DIGITAL_RETINAL_EXAM	Yes	Completed Kit with Member			Select				
HBA1C	Yes	Completed Kit with Member	00000000	00000000	Select				
MICROALBUMIN	No	Select			Select				
FOBT	No	Select	00000000	00000000	Select				
DEXA	No	Select			Select				
PAD	No	Select			Yes				
LDL	No	Select			Select				

Mini-Cog

39. 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.

Home Safety & Personal Goals

40. 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

41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?	Yes	No
b. Do you have electrical cords running across floors, in doorways or under a rugs?	Yes	No
c. Do you have no slip mats on the shower floor or bath tub?	Yes	No
d. Do have adequate lighting in hallways and on the stairs?	Yes	No
e. Do you have handrails on staircases?	Yes	No
f. Is your hot water heater set for a maximum of 120 degrees?	Yes	No
g. Do you have smoke detectors on each level of the house and in all sleeping a rooms?	Yes	No
h. Do you have carbon Monoxide detectors on each level of the house?	Yes	No
i. Have used established an escape route in the event of fire?	Yes	No

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

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

44. Have you ever physically or felt emotionally abused by someone

☐ Yes ☒ No

45. Feeling like harming others or yourself

☐ Yes ☐ No

46. Are you afraid of anyone or is anyone hurting you?

☐ Yes ☐ No

Patient Summary

Assessors Comments :

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 :	
Time exam finished	
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Provider Signature	
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?