

HRA Form

Health Plan :	Tx
Member Name :	Gloria H Adkins
Evaluator Name :	Shannon Lewallen, NP
Assessment Type :	Health Risk Assessment
DOB :	1942-08-18
Evaluation Date :	2021-7-14 04:45 PM
Visit Type :	In Person

Demographics

Plan	Tx
Program	PROGRAM
LOB	LOB
Name	Gloria H Adkins
Gender	Female
Address	
City	
State	
Zip	
Date of Birth	1942-08-18
Age(as of date)	79
Marital Status	Separated
Member Identification Number	788465401
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

- ☒ **Caucasian**
☐ African American
 ☐ Asian
- ☐ Latino
 ☐ Native American
 ☐ Native Hawaiian or other Pacific Islander
- ☐ Alaskan Native
 ☐ Other

## Patient's Ethnicity

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

## 2. Preferred language

- ☐ English
 ☒ **Other**
- ↳ If other,
- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> African languages      | <input 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

[Describe](#)

13. Tobacco use

☐ Current
 ☒ Former
 ☐ Never

Type

☒ Cigarettes
 ☐ Cigars
 ☐ Chewing Tobacco

☐ Vaping
 ☐ Other

How Many

☒ 1 - 3 a day
 ☐ 1/2 a pack
 ☐ 1 pack

☐ More than 1 pack
 ☐ Other

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

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

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

### 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
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

### 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
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	select
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

## Allergies / Medications

### 35. Allergies

☒ Yes ☐ No

Substance	Reaction

### Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
	lisinopril		PO = By Mouth	Select		<input checked="" type="checkbox"/> Taking	<input type="checkbox"/> Not Taking

### 36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
11-12-2021				

### 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	Yes	No

you stop taking it?		
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

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> <b>Cataracts</b> | <input type="checkbox"/> Difficulty with vision |
| <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Hyperopia              |
| <input type="checkbox"/> Macular Degeneration        | <input type="checkbox"/> Myopia                 |
| <input type="checkbox"/> Retinal Disease             | <input type="checkbox"/> Others                 |

#### Cataracts

#### Describe

☒ **Active** ☐ History of ☐ Rule out

comments

Right eye active, left catar

#### Supported by

- |  |   |  |
|--|---|--|
| <input checked="" type="checkbox"/> <b>History</b> | <input checked="" type="checkbox"/> <b>Symptoms</b> | <input type="checkbox"/> Physical Findings |
| <input type="checkbox"/> Medications               | <input type="checkbox"/> Test results               | <input type="checkbox"/> Image studies     |
| <input type="checkbox"/> Biopsy                    | <input type="checkbox"/> DME                        | <input type="checkbox"/> Other             |

comments

sees spec

#### Secondary to Diabetes

☐ Yes ☐ No

### Do you wear glasses or contacts?

☐ Yes ☐ No

### Do you have problems seeing at night?

☐ Yes ☐ No

### Do you have eye pain?

☐ Yes ☐ No

### Do you have problems with tearing?

☐ Yes ☐ No

### Do you have a problem with dry eye?

☐ Yes ☐ No

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

☐ Yes ☒ **No**

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

☒ **Yes** ☐ No

#### Diagnoses

- |  |  |
|--|--|
| <input type="checkbox"/> Chronic Post Nasal Drip | <input type="checkbox"/> Nose Bleeds             |
| <input type="checkbox"/> Sinus Infections        | <input checked="" type="checkbox"/> <b>Other</b> |

#### Other

#### Describe

☒ **Active** ☐ History of ☐ Rule out

#### Supported by



☒ **History**  
☒ **Medications**  
☐ Biopsy

☒ **Symptoms**  
☐ Test results  
☐ DME

☐ Physical Findings  
☐ Image studies  
☐ Other

↳ **Other**

comments

Allergic Rhinitis

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

☒ **Yes**
☐ No

↳ **Diagnoses**

☐ Bleeding Gums
 ☐ Difficulty Chewing  
☐ Difficulty Swallowing
 ☐ Other

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

☐ Yes
 ☒ **No**

## 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**

<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
↳ Route is	
<input checked="" type="checkbox"/> Inhaled	<input type="checkbox"/> Nebulizer <input type="checkbox"/> Oral
↳ Is patient on Steroids	
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
↳ Route is	
<input checked="" type="checkbox"/> Inhaled	<input type="checkbox"/> Nebulizer <input type="checkbox"/> Oral
↳ Does patient have current exacerbation	
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Use of Oxygen	
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
↳ Describe	
<input type="checkbox"/> PRN	<input type="checkbox"/> Continuous <input type="checkbox"/> Day
<input type="checkbox"/> Night	
↳ Litres / Min	
Shortness of breath	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wheezing	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Cough	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient requires durable medical equipment	
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Cardiovascular (Hypertension, Angina, Ischemic Heart Disease(CAD), Myocardial Infarction, Other)	
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> 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	
<input type="checkbox"/> Active (in past 28 days)	<input checked="" type="checkbox"/> History of <input type="checkbox"/> Rule out
↳ Supported by	
<input type="checkbox"/> ECG changes	<input type="checkbox"/> Lab results <input checked="" type="checkbox"/> History of Hospitalization / Procedure for MI
<input checked="" type="checkbox"/> Medications	<input type="checkbox"/> 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 then 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**
☐ **Cachexia**

☐ **Celiac Disease**
☐ **Cirrhosis**

☐ **Colon Polyps**
☐ **Diverticulitis**

☐ **Gall Bladder Disease**
☐ **Gastroparesis**

☐ **GERD**
☐ **Hepatitis**

☐ **Inflammatory Bowel Disease**
☐ **Pancreatitis**

☐ **Ulcer Disease**
☐ **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**

- |   |   |
|---|---|
| <input type="checkbox"/> Alcohol Dependence           | <input type="checkbox"/> Amyotrophic Lateral Sclerosis                |
| <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 type="checkbox"/> Depression                                   |
| <input type="checkbox"/> Drug Dependence              | <input type="checkbox"/> Fibromyalgia                                 |
| <input type="checkbox"/> Generalized Anxiety Disorder | <input type="checkbox"/> Guillain-Barre Disease                       |
| <input type="checkbox"/> Hemiparesis                  | <input type="checkbox"/> Huntington's Chorea                          |
| <input type="checkbox"/> Insomnia                     | <input type="checkbox"/> Intellectual and or Developmental Disability |
| <br>  | <input type="checkbox"/> Multiple Sclerosis                           |
| <input type="checkbox"/> Migraine Headaches           | <input type="checkbox"/> Myasthenia Gravis                            |
| <input type="checkbox"/> Muscular Dystrophy           | <input type="checkbox"/> Peripheral Neuropathy                        |
| <input type="checkbox"/> Parkinson's disease          | <input type="checkbox"/> Schizophrenia                                |
| <input type="checkbox"/> Restless leg syndrome        | <input type="checkbox"/> Spinal Cord Injury                           |
| <input type="checkbox"/> Seizure Disorder             | <input type="checkbox"/> Subdural Hematoma                            |
| <input checked="" type="checkbox"/> <b>Stroke</b>     | <input type="checkbox"/> Traumatic Brain Injury                       |
| <input type="checkbox"/> TIA                          |   |
| <input type="checkbox"/> Other                        |   |

**Stroke**

↳ **Describe**

☐ Active

☒ **History of**

☐ Rule out

↳ **Supported by**

☒ **Hospitalization**

☐ Image study

☒ **Physical findings**

☒ **Sensory findings**

☐ Other

**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?**



- ☐ Flat  
☐ Other
- ☐ Manic
- ☐ 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  
☐ Nearly Every Day
- ☐ Several
- ☐ More than half the days

Feeling down, depressed or hopeless at times?

- ☐ Not at all  
☐ Nearly Every Day
- ☐ Several
- ☐ More than half the days

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

- ☐ Not at all  
☐ Nearly Every Day
- ☐ Several
- ☐ More than half the days

Do you feeling tired or having little energy?

- ☐ Not at all  
☐ Nearly Every Day
- ☐ Several
- ☐ More than half the days

Do you have a poor appetite or overeating?

- ☐ Not at all  
☐ Nearly Every Day
- ☐ Several
- ☐ More than half the days

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

- ☐ Not at all  
☐ Nearly Every Day
- ☐ Several
- ☐ More than half the days

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

- ☐ Not at all  
☐ Nearly Every Day
- ☐ Several
- ☐ More than half the days

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  
☐ Nearly Every Day
- ☐ Several
- ☐ More than half the days

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**

↳ If abnormal

☐ Left

☐ Right

☐ Both

## 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

**ESRD**



Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☐ Lab tests

☐ Calculated GFR X 3

☐ Symptoms

☐ Other

Patient on dialysis

☐ Yes

☐ No

On a special diet

☐ Yes

☐ No

History of frequency

☒ Yes

☐ No



☐ 3x / day

☐ 4x / day

☐ 5x / day

☐ >5x / day

History of Nocturia

☐ Yes

☐ No

History of Hesitancy

☐ Yes

☐ No

Do you have trouble urinating?

☐ Yes

☐ No

Do you ever have blood in your urine?

☐ Yes

☐ No

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

☐ Yes

☐ No

Do you have trouble holding your urine?

☐ Yes

☐ No

Do you trouble getting to the bathroom on time?

☐ Yes

☐ No

Do you ever have pain or burning during urination?

☐ Yes

☐ No

Do you ever wear pads or diapers?

☐ Yes

☐ No

Do you have a vaginal discharge?

☐ Yes

☐ No

Do you have vaginal bleeding?

☐ Yes

☐ No

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

☒ Yes

☐ No

Diagnoses

☐ Collagen (Connective) Tissue Disease

☐ Degenerative Disc Disease

☐ Extremity Fracture (other than Hip)

☐ Gout

☐ Hallux Valgus

☐ Hammer Toes

☐ Onychomycosis

☐ Osteoarthritis

- ☐ Osteomyelitis
- ☐ Pyogenic Arthritis
- ☐ Spinal Stenosis
- ☐ Tinea Pedis

- ☐ Osteoporosis
- ☒ **Rheumatoid Arthritis**
- ☐ Systemic Lupus Erythematosus
- ☐ Other

### Rheumatoid Arthritis

#### Describe

☒ **Active**

☐ History of

☐ Rule out

#### Supported by

☒ **Symptoms**

☐ Physical findings

☐ Lab tests

☐ Image Studies

☐ Other

#### Which joints

comments

knee- pain and swelling

### History / Finding of non- extremity Fracture

☒ **Yes**

☐ No

#### Describe

☐ Traumatic

☐ Pathological

#### Describe

☐ Face

☐ Face

☐ Rib

☐ Pelvis

☐ Other

#### Current (within 12 weeks)

☐ Yes

☐ No

#### Describe fracture/s

### 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

comments

knees swollen due to RA

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

☐ Yes

☐ No

### Do you have pain in your joints?

☐ Yes

☐ No

### 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
- ☐ Eczema
- ☒ **Skin ulcer**
- ☐ Wound

- ☐ Dermatitis
- ☐ Psoriasis
- ☐ Urticarial Disease
- ☐ Other

#### Skin ulcer

##### ↳ Describe

- ☐ Active

- ☐ History of

- ☐ Rule out

##### ↳ Supported by

- ☐ History
- ☐ Medications
- ☐ Biopsy

- ☐ Symptoms
- ☐ Test results
- ☐ DME

- ☐ Physical Findings
- ☐ Image studies
- ☐ Other

##### ↳ Etiology

- ☒ **Pressure**

- ☐ Venous Stasis

- ☐ Peripheral Vascular Disease

- ☐ Disease Induced

- ☐ Diabetic Vasculitis

- ☐ 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

☐ C. Difficile

☒ Anemia

☐ Community Acquired MRSA

☐ HIV

☐ Hospital Acquired MRSA Infection

☐ Leukemia

☐ Multiple Myeloma

☐ 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

History of

☐ Symptoms

☐ Pernicious

☐ Aplastic

☐ Chronic Disease

☐ B 12

☐ Other

Rule out

☐ History of blood transfusion

☐ Kidney disease

☐ Chemotherapy

☐ Folate Deficiency

☐ Folic Acid

Infection

☐ Herpes Zoster

☐ Immune Deficiency

☐ Lymphoma

☐ Sepsis

☐ Sickle Cell Trait

☐ Thrombocytopenia

☐ Vitamin D Deficiency

Easy bruising or abnormal bleeding

☐ Yes

☐ No

Long term anticoagulation use

☐ Yes

☐ No

Cancer

Diagnosis of Cancer	Yes	No
<div><div>Describe</div><div><input type="checkbox"/> Active</div></div>	<div><div>History of</div></div>	<div><div>Rule out</div></div>
<div><div>Supported by</div><div><input type="checkbox"/> Physical findings</div><div><input type="checkbox"/> Lab tests</div><div><input type="checkbox"/> Biopsy</div></div>	<div><div>Hospitalization</div><div><input type="checkbox"/> Imaging studies</div><div><input type="checkbox"/> Other</div></div>	<div><div>Treatments</div><div><input type="checkbox"/> Surgery</div></div>
<div><div>Type</div><div><input type="checkbox"/> Brain</div><div><input type="checkbox"/> Breast</div><div><input type="checkbox"/> Stomach</div><div><input type="checkbox"/> Colon</div><div><input type="checkbox"/> Bladder</div><div><input type="checkbox"/> Prostate</div><div><input type="checkbox"/> Lymph Nodes</div></div>	<div><div>Head</div><div><input type="checkbox"/> Lung</div><div><input type="checkbox"/> Liver</div><div><input type="checkbox"/> Rectum</div><div><input type="checkbox"/> Ovaries</div><div><input type="checkbox"/> Bone</div><div><input type="checkbox"/> Skin</div></div>	<div><div>Neck</div><div><input type="checkbox"/> Esophagus</div><div><input type="checkbox"/> Pancreas</div><div><input type="checkbox"/> Kidney</div><div><input type="checkbox"/> Uterus</div><div><input type="checkbox"/> Blood</div><div><input type="checkbox"/> Other</div></div>
<div><div>Specific type/s</div></div>		

## Stage or Classification specific to the cancer

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

### 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 turbinates:	Normal	Abnormal
Inspection of lips, teeth and gums:	Normal	Abnormal
Examination of oropharynx:	Normal	Abnormal

### Neck

Examination of neck:	Normal	Abnormal
Examination of thyroid:	Normal	Abnormal

### Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
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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			Yes				
HBA1C	Yes	Completed Kit with Member	88888888	88888888	Select			DM 2	
MICROALBUMIN	No	Select			Select				
FOBT	No	Select			Select				
DEXA	No	Select			Select				
PAD	No	Select			Select				
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

- ↳ Who do you feel like harming?
- ↳ Do you feel like this at this moment?
- ↳ Are you in a safe place?
- ↳ Would you like me to assist you to call 911?

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

☒ Yes ☐ No

- ↳ Who are you afraid of? Are you afraid at this moment?
- ↳ Who is hurting you? Are you being hurt at this moment?
- ↳ Are you in a safe place?
- ↳ Would you like me to assist you to call 911?

### 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?