

HRA Form

Health Plan :	Tx
Member Name :	Anton M Adams
Evaluator Name :	Carley Stiglets, NP
Assessment Type :	Health Risk Assessment
DOB :	1956-07-23
Evaluation Date :	2021-7-14 04:44 PM
Visit Type :	In Person

Demographics

Plan	Tx
Program	PROGRAM
LOB	LOB
Name	Anton M Adams
Gender	Female
Address	
City	
State	
Zip	
Date of Birth	1956-07-23
Age(as of date)	65
Marital Status	
Member Identification Number	CC0019529
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 checked="" type="checkbox"/> Caucasian | <input type="checkbox"/> African American | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Latino | <input type="checkbox"/> Native American | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Other | |

Patient's Ethnicity

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

2. Preferred language

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

Previously Documented Conditions

Covid Screening

In the last 14 days, have you:

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

Self-Assessment and Social History

3. How much school have you completed?

- | | | |
|---|---|--|
| <input type="checkbox"/> Less than 3rd grade | <input type="checkbox"/> Completed 3rd grade | <input type="checkbox"/> Completed 8th grade |
| <input type="checkbox"/> Completed 12th grade | <input checked="" type="checkbox"/> 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**
☐ Cigars
 ☐ Chewing Tobacco
☐ Vaping
 ☐ Other
☐ How Many
 ☐ 1 - 3 a day
 ☐ 1/2 a pack
 ☒ **1 pack**
☐ More than 1 pack
 ☐ Other

comments

quit 10 years ago

14. Alcohol Use

☒ **Current**
☐ **Former**
☐ **Never**

How many drinks	How Often
2	Week

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

☐ Yes
☒ **No**

16. Do you have a Healthcare Proxy?

☒ **Yes**
☐ **No**
☐ **Don't Know**

Name

Betty Adams

Relationship

wife

17. Do you have a Durable Power of Attorney?

☒ **Yes**
☐ **No**
☐ **Don't Know**

Name

Betty Adams

Relationship

wife

18. Do you have an Advance Directive?

☐ **Yes**
☒ **No**
☐ **Don't Know**

comments

Educated to begin discussing end of life choices w PCP

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

Comment:

cg assists w bathing, dressing and toileting; ambulates w a RW independently

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

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
comments	Cardiologist - Dr Smith - 999-999-9999	

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](#)

sob and fever; DX w pneumonia; tx Levaquin

C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
-------------------------------------	------	---	---	---	---	-----------

[If one or more, describe](#)

monitored for pneumonia

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](#)

Appendectomy 2010

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

Comment:

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	CAD	MI

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	Yes
Breast Exam/Mammography	No
Cervical Screening	Not Applicable
Bone Density	No
Prostate Exam/PSA	Yes
If Diabetic Eye Exam	Not Applicable
If Diabetic Foot Exam	Not Applicable
If Diabetic Hgb A1c screen	Not Applicable
Lipid Panel	Not Applicable

28. Last colonoscopy if more than 2 years ago

☒ 3 – 5 years ago

☐ 6 – 10 years ago

☐ > 10 years ago

☐ Never ☐ Don't know

comments 1 poly removed - negative for cancer

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

☒ Yes ☐ No ☐ NA

comments a1c 5.8

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

↳ Pneumovax

☐ Yes ☐ No ☒ Unknown

↳ Prevenar

☐ Yes ☐ No ☒ Unknown

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
pcn	rash

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
htn	metoprolol	50mg	PO = By Mouth	BID	dr smith	Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
	mvi		PO = By Mouth	qd

37. Chronic Use of

☐ None

☐ ASA

☐ Steroids

☐ Insulin

☒ Anticoagulants

☐ Statins

☐ Biphosphonate

comments

t

38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?	Yes	No
--	-----	----

Comment: puts in his bathroom to assist w remembering

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

Comment: educated on CAD/CVA prevention

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

☐ Difficulty with vision

☐ Glaucoma

☐ Hyperopia

☐ Macular Degeneration

☐ Myopia

☐ Retinal Disease

☐ Others

Cataracts

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☐ History

☐ Symptoms

☒ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ 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

comments

uses OTC moisturizer drops

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 Chewing

↳ Describe

☐ Active

☒ History of

☐ Rule out

↳ Because of pain

☐ Yes

☒ No

comments

poor dentition

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
 - ☒ **Brinchodilator medication**
 - ☐ Dyspnea on exertion
 - ☐ O2 use
 - ☐ 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**

Shortness of breath

- ☒ **Yes**
- ☐ No

comments

when getting in and out of bed

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

- ☐ Abnormal Cardiac Rhythm
- ☐ Aneurysm
- ☐ Angina
- ☐ Atrial Fibrillation
- ☐ Cardio – Respiratory Failure / Shock
- ☐ Cardiomyopathy
- ☐ Congestive Heart Failure
- ☐ Deep Vein Thrombosis

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

Hyperlipidemia

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☐ Lab results

☒ **Medication**

☐ Other

Is patient on Statin

☒ **Yes**

☐ No

Hypertension

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☐ Physical Exam

☒ **Medications**

☐ Symptoms

☐ Other

Adequately controlled

☒ **Yes**

☐ No

☐ UnKnown

History of Chest Pain

☐ Yes

☒ **No**

History of Intermittent Claudication

☐ Yes

☒ **No**

Implanted Pacemaker

☐ Yes

☒ **No**

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

- | | |
|---|---|
| <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 type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Ulcer Disease | <input type="checkbox"/> Other |

GERD

Describe

☒ Active

Supported by

- ☐ Heartburn /
Dyspepsia
- ☐ Other

☐ History of

☐ Rule out

☐ Regurgitation

☒ Medications

History of blood in stool

☐ Yes ☒ No

History of black stools

☐ Yes ☒ No

History of Heartburn / Dyspepsia

☒ Yes ☐ No

Describe

☒ Occasionally ☐ Chronic

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

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

Do you worry too much about different things?

☐ Yes ☒ No

Do you feel afraid that something bad might happen?

☐ Yes ☒ No

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

☐ Often ☒ Sometimes ☐ Never

GPCOG Score or MMSE Score

GPCOG Score	or MMSE Score

If GPCOG or MMSE is not done, is

↳ Patient oriented to person

☒ Yes ☐ No

↳ Patient oriented to place

☒ Yes ☐ No

↳ Patient oriented to time

☒ Yes ☐ No

↳ Recall

☒ Good ☐ Poor

↳ Patient describes recent news event

☐ Yes ☒ Partially ☐ No

Affect

☒ Normal ☐ Abnormal

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**
- ☐ 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**

☐ Abductor lurch

☐ Ataxic

☐ Limp

☐ Paretic

☐ Other (Findings may also apply to Musculoskeletal diagnoses)

☐ Wide based

☐ Shuffling

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

- ☒ **Yes**

☐ No

Diagnoses

☐ Acute Renal Failure

☐ Chronic Kidney Disease

☐ Erectile Dysfunction

☐ Kidney Stones

☒ **Urinary Incontinence**

Urinary Incontinence

Describe

- ☒ **Active**

☐ History of

☐ Rule out

Supported by

- ☒ **History**

☐ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Related to stress

- ☒ **Yes**

☐ No

↳ Related to

☒ Dribbling

☐ Urgency

☐ Other

↳ Describe

☒ Daily

☐ Few times a week

☐ Less than once a week

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

comments

na

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

Gout

↳ Describe

☐ Active

☒ History of

☐ Rule out

↳ Supported by

- ☐ History of attacks in Foot
- ☐ Lab tests
- ☐ Other

☒ Medications

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

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

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
- ☐ Coronary Artery Disease and Diabetes
- ☐ Diabetes
- ☐ Secondary Hyperparathyroidism
- ☐ Hyperthyroidism
- ☐ Kidney Stone
- ☐ Peripheral Vascular Disease secondary to Diabetes

☐ Hyperparathyroidism
Hypothyroidism

☐ Other

☐ Describe

☒ **Active**

☐ History of

☐ Rule out

☐ Supported by

☐ Weight gain

☐ Fatigue

☐ Hair changes

☐ Depression

☒ **Treatment for hypothyroidism**

☐ Lab data

☐ Other

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
- ☐ Sickle Cell Disease
- ☐ Thalassemia
- ☐ Tuberculosis
- ☐ Other

- ☐ Sepsis
- ☐ Sickle Cell Trait
- ☐ Thrombocytopenia
- ☒ **Vitamin D Deficiency**

Vitamin D Deficiency

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☐ Labs

☒ **Medications**

☐ History

☐ Other

Easy bruising or abnormal bleeding

☐ Yes

☒ **No**

Long term anticoagulation use

☐ Yes

☒ **No**

Cancer

Diagnosis of Cancer	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

R knee, takes Tylenol ii q AM and is effective; used Biofreeze prn

Do you take Methadone

☐ Yes

☐ No

What drug/s do you take for it

Tylenol routine, Biofreeze prn

How bad is your pain on a scale of one to ten with one being very mild and ten being severe

2

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
12/70 (mmHG)	(mmHG)	68 (bpm)	18		97	1

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	8 (Inch)	190 (lbs)	28.9

- ☐ 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

Comment: bilat arcus senilis

Ears, Nose, Mouth and Throat

External Inspection of ears and nose:	Normal	Abnormal
Otoscopic examination:	Normal	Abnormal

Comment: bilat cerumen, mod amt; educated to use debrox

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	Diagnosi s	Commen ts
DIGITAL_RETINAL_EXAM	No	Select			Select				
HBA1C	No	Left Kit	12345678	12345678	Select				
MICROAL BUMIN	No	Select			Select				
FOBT	Yes	Select			Select				
DEXA	No	Select			Select				
PAD	No	Completed Kit with			Select				

		Member							
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 : --

Person's Answers: --

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

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?

I wishes he could loose weith

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

work less

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 :	2021-07-28T18:06

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

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?