

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	GWENDOLYN GOODE
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1962-12-07
Evaluation Date :	

Demographics	
Name	GWENDOLYN GOODE
Gender	Female
Address	8340 MILITARY RD
City	AMELIA COURT HOUSE
State	VA
Zip	23002
Date of Birth	1962-12-07
Age(as of date)	57
Marital Status	
Member Identification Number	11000372
HICN	3J50W25UH29
Phone Number	8045610464
Cell Number	
Email	
Emergency Contact	
Phone Number	
Primary Care Physician	BRYAN, DAPHNE
Phone Number	8047396142
PCP Address	8340 MILITARY RD
PCP City	AMELIA COURT HOUSE
PCP State	VA
PCP Zip	23002
PCP County	AMELIA
Office ID	P0060023
Office Name	ST FRANCIS FAMILY MEDICINE CENTER

1. Race

Answer:

2. Preferred language

Answer:

Current Conditions / Suspect Codes			
Current Conditions			
Date of Service	Diagnosis Code	Diagnosis	
2019-09-25	E11.21	Type 2 diabetes mellitus with diabetic nephropathy	
2019-09-25	E11.59	Type 2 diabetes mellitus with other circulatory complications	
2019-09-25	Z68.43	Body mass index (BMI) 50-59.9, adult	
2019-09-25	Z12.11	Encounter for screening for malignant neoplasm of colon	
2018-02-20	E11.3292	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye	
2019-07-06	I10		
2019-09-25	I63.9	Cerebral infarction, unspecified	
2018-02-20	G81.90	Hemiplegia, unspecified affecting unspecified side	
2019-01-22	E66.01		
2018-02-20	K63.5	Polyp of colon	
2019-09-25	Z91.81	History of falling	
2018-02-20	R60.9	Edema, unspecified	
2018-02-20	Z13.89	Encounter for screening for other disorder	
2019-10-02	E13.9	Other specified diabetes mellitus without complications	
2019-10-02	I63.40	Cerebral infarction due to embolism of unspecified cerebral artery	
2019-09-05	G47.30	Sleep apnea, unspecified	
2018-12-17	Z12.31	Encounter for screening mammogram for malignant neoplasm of breast	
2019-10-02	R03.0	Elevated blood-pressure reading, without diagnosis of hypertension	
2018-04-03	E11.9	Type 2 diabetes mellitus without complications	
2018-04-03	H35.3131	Nonexudative age-related macular degeneration, bilateral, early dry stage	
2018-04-03	H25.13	Age-related nuclear cataract, bilateral	

2019-07-06	L30.9	Dermatitis, unspecified
2018-12-01	G47.33	Obstructive sleep apnea (adult) (pediatric)
2018-12-01	R73.03	
2018-12-01	Z87.891	Personal history of nicotine dependence
2018-12-01	M79.89	Other specified soft tissue disorders
2018-12-01	Z99.89	Dependence on other enabling machines and devices
2019-01-22	Z86.73	Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits
2019-01-22	B35.1	Tinea unguium
2019-09-25	Z23	
2019-09-25	R79.89	Other specified abnormal findings of blood chemistry
2019-09-25	Z00.00	
2019-09-25	Z13.39	Encounter for screening examination for other mental health and behavioral disorders
2019-09-25	Z13.31	Encounter for screening for depression
2019-09-25	Z74.1	Need for assistance with personal care
2019-09-25	D12.5	Benign neoplasm of sigmoid colon
2019-09-25	F41.9	Anxiety disorder, unspecified
2019-09-25	E78.5	Hyperlipidemia, unspecified

Suspect Codes		
Date of Service	Diagnosis Code	Diagnosis
2018-02-20	G81.90	Hemiplegia, unspecified affecting unspecified side

Screenings Needed				
Screening Name	Member Eligible	Screening Completed	Screening Result	Diagnosis
DIGITAL_RETINAL_EXAM	Yes	Select		
HBA1C	No	Select		
MICROALBUMIN	No	Select		
FOBT	No	Select		
DEXA	No	Select		
Flu Shot	Select	Select		
PAD	Select	Select		

Spirometry	Select	Select		
LDL	Select	Select		

Self-Assessment and Social History

3. How much school have you completed?
Answer:

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

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

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

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

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

9. Where do you currently live?
Answer:

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

11. Who do you currently live with?
Answer:

12. Are you currently a caregiver for someone?
Answer:

13. Tobacco use
Answer:

14. Alcohol Use
Answer:

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

16. Do you have a Healthcare Proxy?
Answer:

17. Do you have a Durable Power of Attorney?
Answer:

18. Do you have an Advance Directive?

Answer:

Activities of Daily Living

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

A. Getting in or out of bed

Answer:

B. Getting in or out of chairs

Answer:

C. Toileting

Answer:

D. Bathing

Answer:

E. Dressing

Answer:

F. Eating

Answer:

G. Walking

Answer:

H. Going up or down stairs

Answer:

Medical History

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

Answer:

Comment:

21. Are you currently seeing any specialists?

Medical Specialty	Specialist	For
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22. In the past 12 months how many times have you?

A. Seen your PCP

Answer:

B. Visited the Emergency Room

Answer:

C. Stayed in the hospital overnight

Answer:

<div>D. Been in a nursing home <i>Answer:</i></div> <div>E. Had Surgery <i>Answer:</i></div>
<div>23. Have you ever been hospitalized prior to the last 12 months? <i>Answer:</i></div>
<div>24. In the past year have you received health services from any of the providers below: <div>Physical Therapist <i>Answer:</i></div><div>Occupational Therapist <i>Answer:</i></div><div>Dietician <i>Answer:</i></div><div>Social Worker <i>Answer:</i></div><div>Pharmacist <i>Answer:</i></div><div>Speech Therapist <i>Answer:</i></div><div>Chiropractor <i>Answer:</i></div><div>Personal Care Worker (HHA, CNA, PCA) <i>Answer:</i></div><div>Meals on Wheels <i>Answer:</i></div></div>
<div>25. In the past two years have you received any of the treatments below? <div>Chemotherapy <i>Answer:</i></div><div>Catheter Care <i>Answer:</i></div><div>Oxygen <i>Answer:</i></div><div>Wound Care <i>Answer:</i></div><div>Regular Injections</div></div>

Answer:

Tube Feedings

Answer:

Family History

26. Family History

Family Member	Medical Condition	Cause of Death
Select Family Member		

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

Answer:

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

Answer:

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

Answer:

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

Answer:

32. Do you get Flu Vaccine each year?

Answer:

33. Have you been vaccinated for Pneumonia?

Answer:

34. Have you been vaccinated for Herpes Zoster?

Answer:

Allergies / Medications

35. Allergies

Answer:

Substance	Reaction
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Medications

Dose Date	Label Name	Dose / Units	Route	Frequency	Status
2019-07-15	AMLODIPINE	5MG	Select	Select	
2019-09-02	METFORMIN	500MG	Select	Select	
2019-09-12	CHLORTHALID	50MG	Select	Select	
2019-08-16	LOSARTAN POT	100MG	Select	Select	
2019-06-13	ATORVASTATIN	10MG	Select	Select	
2018-07-06	PEG-3350/KCL	/SODIUM	Select	Select	
2018-11-06	IBU	800MG	Select	Select	
2018-02-11	HYDROCHLOROT	25MG	Select	Select	
2019-06-13	FLUOXETINE	20MG	Select	Select	
2019-01-22	TERBINAFINE	250MG	Select	Select	
2018-02-14	FUROSEMIDE	20MG	Select	Select	

36. Over the Counter Medications / Supplements

Answer:

Date	Description	Dose/Units	Route	Frequency
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37. Chronic Use of

Answer:

Comment:

38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?

Answer:

2. Do you sometimes not pay enough attention to your medication?

Answer:

3. Do you know the longterm benefit of taking your medicine as told to you by the doctor or pharmacist?

Answer:

4. When you feel better do you sometimes stop taking your medicine?

Answer:

5. Sometimes if you feel worse when you take your medicine do you stop taking it?

Answer:

6. Do you sometimes forget to refill your prescription on time?

Answer:

Review of Systems and Diagnoses
<div>EYES</div> <div>Eye Problems (Glaucoma, Cataracts, Macular Degeneration, Blindness, Retinal Detachment, Other)</div> <div>Answer:</div>
<div>EARS</div> <div>Ear Problems (Hard of hearing, Deaf, Vertigo, Ear Infections)</div> <div>Answer:</div>
<div>NOSE</div> <div>Nose Problems (Nose Bleeds, Sinus infections, Other)</div> <div>Answer:</div>
<div>MOUTH AND THROAT</div> <div>Mouth and Throat Problems (Difficulty Chewing, Difficulty Swallowing, Bleeding Gums, Other)</div> <div>Answer:</div>
<div>NECK</div> <div>Neck Problems (parotid Disease, Carotid Stenosis, Other)</div> <div>Answer:</div>
<div>RESPIRATORY</div> <div>Respiratory Problems (COPD, Emphysema, Asthma, Chronic Bronchitis Pneumonia, Other)</div> <div>Answer:</div>
<div>CARDIOVASCULAR</div> <div>Cardiovascular (Hypertension, Angina, Ischemic Heart Disease(CAD), Myocrdial Infarction, Other)</div> <div>Answer:</div>
<div>GASTROINTESTINAL</div> <div>Gastrointestinal Problems (Ulcer, Reflux, Hiatal Hernia, Colitis, Other)</div> <div>Answer:</div>
<div>Bowel Movements</div>

Answer:	
Abdominal Openings	
Answer:	
Rectal Problems	
Answer:	
Last Bowel Movement	
Answer:	
NEURO-PSYCH	
Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)	
Answer:	
Are you nervous, anxious, feel on the edge or often feel stressed?	
Answer:	
Do you worry too much about different things?	
Answer:	
Do you feel afraid that something bad might happen?	
Answer:	
How often do you go out to meet with family or friends	
Answer:	
GPCOG Score	
or MMSE Score	
If GPCOG or MMSE is not done, is	
Patient oriented to person	
Answer:	
Patient oriented to place	
Answer:	
Patient oriented to time	
Answer:	
Recall	
Answer:	
Patient describes recent news event	
Answer:	
Affect	
Answer:	
Over the past 2 weeks, how often have you been bothered by any of the following problems?	

<div><div>Little interest or pleasure in doing things</div><div>Answer:</div><div>Feeling down, depressed or hopeless</div><div>Answer:</div><div>PHQ 2 Score : 0</div></div>
<div><div>Speech</div><div>Answer:</div></div>
<div><div>Finger to Nose</div><div>Answer:</div></div>
<div><div>Heel (Shin) to Toe</div><div>Answer:</div></div>
<div><div>Thumb to Finger Tips</div><div>Answer:</div></div>
<div><div>Sitting to Standing</div><div>Answer:</div></div>
<div><div>Facial / Extremity Movement</div><div>Answer:</div></div>
<div><div>Gait</div><div>Answer:</div></div>
<div><div>GENITOURINARY</div><div>Genitourinary Problems (Overactive Bladder, Urinary Incontinence Stress Incontinence,Benign Prastatic Hypertraphy, Others)</div><div>Answer:</div></div>
<div><div>MUSCULOSKELETAL</div><div>Musculoskeletal Problems (Spinal Stenosis, Rheumatoid Arthritis, Gout, Osteoporosis, Others)</div><div>Answer:</div></div>
<div><div>INTEGUMENT</div><div>Integument Problems (Eczema, Psoriasis, Dermatitis, Urticaria, Other)</div><div>Answer:</div></div>
<div><div>ENDOCRINE</div></div>

Endocrine Problems

Answer:

Have you lost weight in the past 6 months?

Answer:

HEMATOLOGY / IMMUNOLOGY / INFECTIOUS DISEASE

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

Answer:

CANCER

Diagnosis of Cancer

Answer:

Pain

Does the patient experience pain?

Answer:

Vital Signs

Vital Signs

Blood Pressure	
Pulse	
Respiratory Rate	
Temp	
Pulse Oximetry	
Pain Scale /10	

BMI

Patients Height	
Patients Weight	
BMI	

Obesity Level

Answer:

Exam Review

Constitutional

General appearance:

Answer:
Head and Face
Examination of head and face: Answer:
Palpation of the face and sinuses: Answer:
Eyes
Inspection of conjunctiva and lids: Answer:
Examination of pupils and irises: Answer:
Ears, Nose, Mouth and Throat
External Inspection of ears and nose: Answer:
Otoscopic examination: Answer:
Assessment of hearing: Answer:
Inspection of nasal mucosa, septum and trubينات: Answer:
Inspection of lips, teeth and gums: Answer:
Examination of oropharynx: Answer:
Neck
Examination of neck: Answer:
Examination of thyroid: Answer:
Pulmonary
Assessment of respiratory effort:

Answer:
Percussion of chest: Answer:
Palpation of chest: Answer:
Auscultation of lungs: Answer:

Cardiovascular
Palpation of heart: Answer:
Auscultation of heart: Answer:
Carotid Arteries: Answer:
Abdominal Aorta: Answer:
Femoral Arteries: Answer:
Pedal Pulses: Answer:
Examination of Arterial Pulses: Answer:
Examination of Edema / Varicosities: Answer:

Lymphatic
Palpation of lymph nodes in neck: Answer:
Palpation of lymph nodes in axillae: Answer:
Palpation of lymph nodes in groin: Answer:
Palpation of lymph nodes in other areas: Answer:

Musculoskeletal
Examination of gait and station: <i>Answer:</i>
Inspection/palpation of digits and nails: <i>Answer:</i>
Inspection/palpation of joints, bones and muscles: <i>Answer:</i>
Assessment of range of motion: <i>Answer:</i>
Assessment of stability: <i>Answer:</i>
Assessment of muscle strength/tone: <i>Answer:</i>

Skin
Inspection of skin and subcutaneous tissue: <i>Answer:</i>
Palpation of skin and subcutaneous tissue: <i>Answer:</i>

Neurologic
Examination of cranial nerves: <i>Answer:</i>
Examination of reflexes: <i>Answer:</i>
Examination of sensation: <i>Answer:</i>
Coordination: <i>Answer:</i>

Diabetes
Foot Exam: <i>Answer:</i>

Psychiatric
Description of patient's judgement / insight:

Answer:
Orientation of person, place and time: Answer:
Recent and remote memory: Answer:
Mood and affect: Answer:

Mini-Cog	
Word List Version	
Person's Answers	
Word Recall	
Clock Draw	
Total Score	

Home Safety & Personal Goals
40. In the past year how many times have you Fallen? Answer:
41. Home Safety a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping? Answer: b. Do you have electrical cords running across floors, in doorways or under a rugs? Answer: c. Do you have no slip mats on the shower floor or bath tub? Answer: d. Do have adequate lighting in hallways and on the stairs? Answer: e. Do you have handrails on staircases? Answer: f. Is your hot water heater set for a maximum of 120 degrees? Answer: g. Do you have smoke detectors on each level of the house and in all sleeping a rooms? Answer:

