

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	FELIKA STANBACK
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1987-06-20
Evaluation Date :	

Demographics	
Name	FELIKA STANBACK
Gender	Female
Address	4220 ANNE TERRACE
City	PRINCE GEORGE
State	VA
Zip	23875
Date of Birth	1987-06-20
Age(as of date)	32
Marital Status	
Member Identification Number	11000379
HICN	1YM3D60VA98
Phone Number	8047213070
Cell Number	
Email	
Emergency Contact	
Phone Number	
Primary Care Physician	CHIU, GRACE H
Phone Number	8048296600
PCP Address	4220 ANNE TERRACE
PCP City	PRINCE GEORGE
PCP State	VA
PCP Zip	23875
PCP County	PRINCE GEORGE
Office ID	P9058737
Office Name	HOPEWELL PRINCE GEORGE COMMUNITY HEALTH CENTER

1. Race

Answer:

2. Preferred language

Answer:

Current Conditions / Suspect Codes		
Current Conditions		
Date of Service	Diagnosis Code	Diagnosis
2019-03-19	D89.89	Other specified disorders involving the immune mechanism, not elsewhere classified
2019-03-19	M32.19	Other organ or system involvement in systemic lupus erythematosus
2019-03-19	D72.819	Decreased white blood cell count, unspecified
2019-03-19	M35.00	
2019-12-06	E55.9	Vitamin D deficiency, unspecified
2019-03-28	R07.9	Chest pain, unspecified
2019-03-28	R06.02	
2019-03-28	R00.2	Palpitations
2019-03-28	R00.0	Tachycardia, unspecified
2018-11-01	I32	
2019-03-28	I34.0	Nonrheumatic mitral (valve) insufficiency
2019-12-06	M32.9	Systemic lupus erythematosus, unspecified
2019-03-28	R09.1	Pleurisy
2018-04-24	R10.9	Unspecified abdominal pain
2018-01-24	Z09	
2018-01-30	J20.9	Acute bronchitis, unspecified
2018-01-30	E66.9	Obesity, unspecified
2018-03-28	Z79.899	Other long term (current) drug therapy
2019-03-28	I36.1	Nonrheumatic tricuspid (valve) insufficiency
2018-04-24	L20.9	Atopic dermatitis, unspecified
2018-04-24	M25.561	Pain in right knee
2018-04-24	N20.0	Calculus of kidney
2019-11-07	Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
2019-11-07	Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission

2019-11-07	Z30.09	
2019-11-07	Z12.4	Encounter for screening for malignant neoplasm of cervix
2019-11-07	R87.612	Low grade squamous intraepithelial lesion on cytologic smear of cervix (LGSIL)
2018-11-10	J90	
2018-10-13	I11.9	Hypertensive heart disease without heart failure
2018-10-15	I10	
2018-10-13	D63.8	Anemia in other chronic diseases classified elsewhere
2018-10-13	T38.0X5A	Adverse effect of glucocorticoids and synthetic analogues, initial encounter
2018-10-14	E86.0	Dehydration
2018-11-10	Z86.711	Personal history of pulmonary embolism
2018-10-13	Z79.01	
2018-10-04	M25.50	Pain in unspecified joint
2018-07-31	R79.1	Abnormal coagulation profile
2018-10-16	I31.3	Pericardial effusion (noninflammatory)
2018-10-04	R31.9	Hematuria, unspecified
2018-10-09	J98.4	Other disorders of lung
2018-11-10	J18.9	Pneumonia, unspecified organism
2018-11-10	R07.89	Other chest pain
2018-02-26	N28.89	Other specified disorders of kidney and ureter
2018-10-02	N39.0	Urinary tract infection, site not specified
2018-10-02	R35.1	Nocturia
2018-10-02	R31.21	Asymptomatic microscopic hematuria
2018-11-10	R05	
2018-11-10	Z87.891	Personal history of nicotine dependence
2018-11-10	Z88.0	Allergy status to penicillin
2018-11-10	Z91.013	
2018-10-15	J98.11	Atelectasis
2018-11-19	D64.9	Anemia, unspecified
2019-01-17	M25.521	Pain in right elbow
2019-01-17	M24.529	Contracture, unspecified elbow
2018-02-26	R82.3	Hemoglobinuria
2018-08-05	S29.011A	Strain of muscle and tendon of front wall of thorax,

			initial encounter
2018-08-05	X58.XXXA		Exposure to other specified factors, initial encounter

Suspect Codes		
Date of Service	Diagnosis Code	Diagnosis

Screenings Needed				
Screening Name	Member Eligible	Screening Completed	Screening Result	Diagnosis
DIGITAL_RETINAL_EXAM	No	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:

<b>10. Do you have someone you can rely on to help if you are sick or have problems you need to discuss?</b> <i>Answer:</i>
<b>11. Who do you currently live with?</b> <i>Answer:</i>
<b>12. Are you currently a caregiver for someone?</b> <i>Answer:</i>
<b>13. Tobacco use</b> <i>Answer:</i>
<b>14. Alcohol Use</b> <i>Answer:</i>
<b>15. Do you or have you used recreational drugs or pain medication?</b> <i>Answer:</i>
<b>16. Do you have a Healthcare Proxy?</b> <i>Answer:</i>
<b>17. Do you have a Durable Power of Attorney?</b> <i>Answer:</i>
<b>18. Do you have an Advance Directive?</b> <i>Answer:</i>

<b>Activities of Daily Living</b>
<b>19. Do you have any difficulty with the following activities?</b>  <b>A. Getting in or out of bed</b> <i>Answer:</i>  <b>B. Getting in or out of chairs</b> <i>Answer:</i>  <b>C. Toileting</b> <i>Answer:</i>  <b>D. Bathing</b> <i>Answer:</i>  <b>E. Dressing</b> <i>Answer:</i>  <b>F. Eating</b> <i>Answer:</i>  <b>G. Walking</b> <i>Answer:</i>

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:

D. Been in a nursing home

Answer:

E. Had Surgery

Answer:

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

Answer:

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

Physical Therapist

Answer:

Occupational Therapist

Answer:

Dietician

Answer:

Social Worker

Answer:

Pharmacist

Answer:

Speech Therapist

Answer:

**Chiropractor**  
*Answer:*

**Personal Care Worker (HHA, CNA, PCA)**  
*Answer:*

**Meals on Wheels**  
*Answer:*

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

**Chemotherapy**  
*Answer:*

**Catheter Care**  
*Answer:*

**Oxygen**  
*Answer:*

**Wound Care**  
*Answer:*

**Regular Injections**  
*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
2018-08-22	MYCOPHENOLAT	200MG/ML	Select	Select	
2019-08-02	XARELTO	20MG	Select	Select	
2018-10-17	DILTIAZEM	120MG ER	Select	Select	
2019-01-21	HYDROXYCHLOR	200MG	Select	Select	
2018-10-03	SMZ/TMP DS	800-160	Select	Select	
2019-08-07	PREDNISONE	10MG	Select	Select	
2018-10-17	LEVOFLOXACIN	250MG	Select	Select	
2019-08-07	AZATHIOPRINE	50MG	Select	Select	
2018-07-31	IBUPROFEN	800MG	Select	Select	
2018-10-11	PROAIR HFA		Select	Select	
2018-01-30	AZITHROMYCIN	500MG	Select	Select	

36. Over the Counter Medications / Supplements

Answer:



Date	Description	Dose/Units	Route	Frequency
<div>37. Chronic Use of</div> <div>Answer:</div> <div>Comment:</div>				
<div>38. Medication Compliance and Knowledge of Use and Disease</div> <div>1. Do you ever forget to take your medicine?</div> <div>Answer:</div> <div>2. Do you sometimes not pay enough attention to your medication?</div> <div>Answer:</div> <div>3. Do you know the longterm benefit of taking your medicine as told to you by the doctor or pharmacist?</div> <div>Answer:</div> <div>4. When you feel better do you sometimes stop taking your medicine?</div> <div>Answer:</div> <div>5. Sometimes if you feel worse when you take your medicine do you stop taking it?</div> <div>Answer:</div> <div>6. Do you sometimes forget to refill your prescription on time?</div> <div>Answer:</div>				

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>

Answer:
<b>NECK</b>
Neck Problems (parotid Disease, Carotid Stenosis, Other)
Answer:
<b>RESPIRATORY</b>
Respiratory Problems (COPD, Emphysema, Asthma, Chronic Bronchitis Pneumonia, Other)
Answer:
<b>CARDIOVASCULAR</b>
Cardiovascular (Hypertension, Angina, Ischemic Heart Disease(CAD), Myocrdial Infarction, Other)
Answer:
<b>GASTROINTESTINAL</b>
Gastrointestinal Problems (Ulcer, Reflux, Hiatal Hernia, Colitis, Other)
Answer:
<b>Bowel Movements</b>
Answer:
<b>Abdominal Openings</b>
Answer:
<b>Rectal Problems</b>
Answer:
<b>Last Bowel Movement</b>
Answer:
<b>NEURO-PSYCH</b>
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:

<b>How often do you go out to meet with family or friends</b> <i>Answer:</i>	
GPCOG Score	
or MMSE Score	
<b>If GPCOG or MMSE is not done, is</b>  <b>Patient oriented to person</b> <i>Answer:</i>  <b>Patient oriented to place</b> <i>Answer:</i>  <b>Patient oriented to time</b> <i>Answer:</i>  <b>Recall</b> <i>Answer:</i>  <b>Patient describes recent news event</b> <i>Answer:</i>	
<b>Affect</b> <i>Answer:</i>	
<b>Over the past 2 weeks, how often have you been bothered by any of the following problems?</b>  <b>Little interest or pleasure in doing things</b> <i>Answer:</i>  <b>Feeling down, depressed or hopeless</b> <i>Answer:</i>  <b>PHQ 2 Score : 0</b>	
<b>Speech</b> <i>Answer:</i>	
<b>Finger to Nose</b> <i>Answer:</i>	
<b>Heel (Shin) to Toe</b> <i>Answer:</i>	
<b>Thumb to Finger Tips</b> <i>Answer:</i>	
<b>Sitting to Standing</b> <i>Answer:</i>	

<b>Facial / Extremity Movement</b> <i>Answer:</i>
<b>Gait</b> <i>Answer:</i>
<b>GENITOURINARY</b>  <b>Genitourinary Problems (Overactive Bladder, Urinary Incontinence Stress Incontinence,Benign Prastatic Hypertraphy, Others)</b> <i>Answer:</i>
<b>MUSCULOSKELETAL</b>  <b>Musculoskeletal Problems (Spinal Stenosis, Rheumatoid Arthritis, Gout, Osteoporosis, Others)</b> <i>Answer:</i>
<b>INTEGUMENT</b>  <b>Integument Problems (Eczema, Psoriasis, Dermatitis, Urticaria, Other)</b> <i>Answer:</i>
<b>ENDOCRINE</b>  <b>Endocrine Problems</b> <i>Answer:</i>
<b>Have you lost weight in the past 6 months?</b> <i>Answer:</i>
<b>HEMATOLOGY / IMMUNOLOGY / INFECTIOUS DISEASE</b>  <b>Hematology / Immunology / Infection Disease Problems (Anemia, easy bruising or abnormal bleeding Thrombocytopenia , Other)</b> <i>Answer:</i>
<b>CANCER</b>  <b>Diagnosis of Cancer</b> <i>Answer:</i>
<b>Pain</b>
<b>Does the patient experience pain?</b> <i>Answer:</i>

**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:

<b>Otoscopic examination:</b> <i>Answer:</i>
<b>Assessment of hearing:</b> <i>Answer:</i>
<b>Inspection of nasal mucosa, septum and trubينات:</b> <i>Answer:</i>
<b>Inspection of lips, teeth and gums:</b> <i>Answer:</i>
<b>Examination of oropharynx:</b> <i>Answer:</i>

<b>Neck</b>
<b>Examination of neck:</b> <i>Answer:</i>
<b>Examination of thyroid:</b> <i>Answer:</i>

<b>Pulmonary</b>
<b>Assessment of respiratory effort:</b> <i>Answer:</i>
<b>Percussion of chest:</b> <i>Answer:</i>
<b>Palpation of chest:</b> <i>Answer:</i>
<b>Auscultation of lungs:</b> <i>Answer:</i>

<b>Cardiovascular</b>
<b>Palpation of heart:</b> <i>Answer:</i>
<b>Auscultation of heart:</b> <i>Answer:</i>
<b>Carotid Arteries:</b> <i>Answer:</i>
<b>Abdominal Aorta:</b> <i>Answer:</i>

<b>Femoral Arteries:</b> <i>Answer:</i>
<b>Pedal Pulses:</b> <i>Answer:</i>
<b>Examination of Arterial Pulses:</b> <i>Answer:</i>
<b>Examination of Edema / Varicosities:</b> <i>Answer:</i>

<b>Lymphatic</b>
<b>Palpation of lymph nodes in neck:</b> <i>Answer:</i>
<b>Palpation of lymph nodes in axillae:</b> <i>Answer:</i>
<b>Palpation of lymph nodes in groin:</b> <i>Answer:</i>
<b>Palpation of lymph nodes in other areas:</b> <i>Answer:</i>

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

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

<b>Palpation of skin and subcutaneous tissue:</b> <i>Answer:</i>	
<b>Neurologic</b>	
<b>Examination of cranial nerves:</b> <i>Answer:</i>	
<b>Examination of reflexes:</b> <i>Answer:</i>	
<b>Examination of sensation:</b> <i>Answer:</i>	
<b>Coordination:</b> <i>Answer:</i>	
<b>Diabetes</b>	
<b>Foot Exam:</b> <i>Answer:</i>	
<b>Psychiatric</b>	
<b>Description of patient's judgement / insight:</b> <i>Answer:</i>	
<b>Orientation of person, place and time:</b> <i>Answer:</i>	
<b>Recent and remote memory:</b> <i>Answer:</i>	
<b>Mood and affect:</b> <i>Answer:</i>	
<b>Mini-Cog</b>	
Word List Version	
Person's Answers	
Word Recall	
Clock Draw	
Total Score	
<b>Home Safety &amp; Personal Goals</b>	



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:

h. Do you have carbon Monoxide detectors on each level of the house?

Answer:

i. Have used established an escape route in the event of fire?

Answer:

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

Answer:

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

Answer:

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

Answer:

Active Problem Conditions

ICD 10	ICD-10 Description	DX Assmt	Monitor & Eval	Tx Plan
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Patient Summary

Assessors Comments	
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Member informed of acknowledgment	true
Time exam Started	
Time exam finished	
Date of Service/Evaluation	
Provider Signature	<div><div>shwetha kV</div><div>Digitally signed by shwetha kV, Speciali 2020-04-27 16:39</div></div>