Appendix 25 ▪ Initial Health Assessment

Instructions: Inquire about each area as appropriate, and enter a response or indicate if not applicable in the comments. It is necessary to record a response to each area of the assessment.

Participant Name: _____ MSSP ID: _____

Assessment Date: _____

Staff Name/Title: _____ Staff Signature: _____

Diagnosis/Medical History

What are the participant's diagnoses?

_____

What is the participant's medical history?

_____

What is the participant's rating of own health? ☐Poor ☐Fair ☐Good ☐Excellent

Has the participant been in a hospital, SNF, or ER in past year? ☐Yes ☐No
If yes, provide approximate date(s) and reason(s)?

_____

Medications

Pharmacy used: _____

☐ Allergies to Medications ☐ Forgets Medications ☐ Problem with Cost

☐ Medications prescribed are covered by Medicare

☐ Has prescription medications in stock which are no longer prescribed and/or expired

☐ Primary physician knows about all of the participant's medications

Does the participant have help with medications? ☐ Yes ☐ No
If yes, who helps? What kind of help? _____

Is more help with medications needed? ☐ Yes ☐ No
If yes, describe: _____

Comments:

_____

Nutritional Assessment

Include in your assessment:

- Usual eating
- Diet patterns
- Preparation of meals
- Shopping
- Finances
- Allergies

Weight loss or gain in past year:

Special diet/restricted foods:

Participant follows diet:

Participant's reported appetite: ☐ Good ☐ Fair ☐ Poor

Meals per day: ☐ 1 ☐ 2 ☐ 3

Nurse's assessment of participant's diet quality:

Nutritional Supplements? (Note: If MSSP will purchase using Waiver Service funds, please refer to Chapter 3, Section 3.1430 Purchased Waiver Services, Oral Nutritional Supplements [7.3] and complete Appendix 31: Determine Your Nutritional Health).

Approximate amount/type of fluid intake:

Comments:

Health Habits

Describe usual use patterns and significant changes, if applicable:
Tobacco:

Caffeine:

Alcohol:

History of alcohol/drug abuse:

Sleep Pattern:

Comments:

Review of Systems

Instructions: Check each condition identified by participant or observed during the assessment. Inquire about each area as appropriate and enter response or indicate if not a problem by stating “none” or “N/A”. It is necessary to record a response to each condition. Comments should include changes, impact of condition on function, and whether a medical care provider is overseeing the participant’s care. For example, if the participant is seeing a cardiologist, this should be listed in the comment box in the cardiovascular section.

Eyes: ☐ Glasses or Contact lens ☐ Trouble with vision ☐ Change in vision in last year
Comments:

Ears: ☐ Trouble with hearing ☐ Wears a hearing aid
Comments:

Mouth: ☐ Problems with teeth/gums ☐ Dentures ☐ Problems with Dentures
☐ Dentures fit well
Comments:

Respiratory/Pulmonary: ☐ Short of Breath ☐ Uses Oxygen ☐ Coughs Frequently
☐ Diagnosis of Tuberculosis ☐ Uses Inhaler
Comments:

Cardiovascular: ☐ Pain, Tightness, or pressure in chest, neck, or arms
☐ Swelling of Feet or ankles ☐ Prop pillows at night for shortness of breath
☐ Fainting/Blackouts ☐ Rapid, irregular, or skipped heartbeats ☐ High Blood Pressure
☐ Cramps in leg muscles ☐ When walking ☐ When not walking
Comments:

Breasts: ☐ History of Breast Cancer ☐ Lumps ☐ Mammogram Approx. Date: _____
☐ Performs Breast Self-Exam
Comments:

Gastrointestinal: ☐ Trouble swallowing ☐ Indigestion/heartburn ☐ Nausea/vomiting
☐ Constipation ☐ Change in bowel habits ☐ Loose stools or diarrhea
☐ Blood from rectum ☐ Bowel incontinence ☐ Black or tarry stools
Comments:

Genitourinary: ☐ History of bladder disease ☐ Catheter ☐ Incontinence
☐ Frequency at night ☐ Urgency ☐ Trouble starting/stopping urine
☐ Pain/burning with urination ☐ Chronic UTIs
Comments:

Vaginal Problems: ☐ Bleeding ☐ Discharge ☐ Odor ☐ Bulging ☐ Itching
Comments:

Testicular/Prostate:
Comments:

Musculoskeletal: ☐ Back pain ☐ Falls ☐ Osteoporosis ☐ Joint pain or stiffness
☐ Engages in physical activities ☐ Changes in activity level ☐ Foot problems
Comments:

Mobility: ☐ Fully ambulatory ☐ Ambulatory with assistance ☐ Cane/Walker
☐ Prosthesis/appliance ☐ Occasional Wheelchair use ☐ Bed Bound
Gait (if observed): _____
☐ Ataxia ☐ Unsteady ☐ Poor Balance ☐ Shuffling ☐ Wide Based
Describe need for foot care: _____
If bed bound, describe ROM: _____
Joint deformity description: _____
Comments:

Neurological: ☐ CVA ☐ Numbness in arm, leg or face ☐ Paralysis ☐ Headaches
☐ Trouble finding words/slurred speech ☐ Dizziness ☐ Tremors
☐ Weakness ☐ Seizures
Comments:

Psychiatric: ☐ Confused ☐ Wanders ☐ Feelings of Depression
☐ Psychiatric History ☐ Changes in Memory
Comments:

Endocrine: ☐ Diabetes ☐ Insulin Dependent ☐ Controlled Diet
☐ Oral Hypoglycemics ☐ Thyroid Problems
Comments:

Skin: ☐ Rash/Redness ☐ Dry Skin ☐ Itching ☐ Growths ☐ Wounds/lesions
☐ Changes in wart or mole ☐ Sores that will not heal/pressure injuries
Skin Characteristics:

☐ Warm ☐ Cool ☐ Dry ☐ Moist ☐ Color
Comments:

Vital Signs (If not taken, explain in comments):

BP: _____ ☐ Sitting ☐ Supine ☐ Standing Pulse: _____ Respirations: _____

Weight (history or taken):_____ Height (by history):_____

Pain: ☐ No Pain ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe ☐ Worst Possible

Temperature (optional):_____

Comments:

Who provided assessment information:

Name:_____ Relationship: _____

How reliable is provided information?_____
Comments:

Was this assessment conducted in the participant's home? ☐ Yes ☐ No
(if no, where?) _____

Does the participant have an advanced directive? ☐ Yes ☐ No
Comments:

Participant Needs List: