Comprehensive Geriatric Assessment Form

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Patient's name ---------- Date----------
MRN---------- Date of Birth ----------
Accompanied by ----------

Reason/s for Referral

History of Presenting Illness/ Main Issues

Past Medical History	Past Psychiatric History
• HTN • Dyslipidemia • DM (OHA/Insulin) • CAD/stents/CHF • A.Fib/ Pacemaker • Stroke/TIA • Arthritis (OA, RA) • Osteoporosis • Thyroid • Parkinson's • Cancer • Other	• Depression • Dementia • Delirium • Psychosis • Other **Past Surgical History** • Cholecystectomy/appendectomy • CABG/ PCI/Stent • TURP • Hip fracture/ Joint replacement • Other

Medications

1. Name, dose, frequency
2.

Vaccines

1. Pneumococcal vaccine: Type:_____, Date_____
2. Last Influenza vaccine
3. Zoster vaccine: Date_____
4. Td vaccine: Date_____

PRN/Non-Prescription and Herbals and Vitamins

- Administration: --Self ---supervised
- Understanding Meds: --Poor ---Adequate
- Adherence: --Good ---Adequate --Poor

Allergies/Reactions to Medications

Allergy to_____ Type of reaction_____

Functional Status (self-report)

Basic Activities of Daily Living (BADLs)/ Katz Index					
	Feeding	Independent	Supervised	Assisted	Dependent
	Dressing	Independent	Supervised	Assisted	Dependent
	Bathing	Independent	Supervised	Assisted	Dependent
	Toileting	Independent	Supervised	Assisted	Dependent
	Ambulation (+/- aid)	Independent	Supervised	Assisted	Dependent
	Transfers/ Stairs	Independent	Supervised	Assisted	Dependent
	Praying	Independent	Supervised	Assisted	Dependent
Instrumental Activities of Daily Living (IADLs)/ Lawton Scale					
	Driving:	Independent	Supervised	Assisted	Dependent
	Shopping	Independent	Supervised	Assisted	Dependent
	cooking	Independent	Supervised	Assisted	Dependent
	Housework	Independent	Supervised	Assisted	Dependent
	Laundry	Independent	Supervised	Assisted	Dependent
	Banking/finance	Independent	Supervised	Assisted	Dependent
	Medications	Independent	Supervised	Assisted	Dependent
	Ability to Use Telephone	Independent	Supervised	Assisted	Dependent
Advanced Activities of Daily Living (AADLs)					
	Hobbies/ Socialization	Out and about	House-bound	Wheelchair-bound	Bed-bound

Home Safety Issues

- leaves stove on/ water running.
- Wandering

Assistive Devices

- Walker
- Cane
- Wheelchair
- Devices at home: bath seat, Commode/ raised toilet seat/ bath grab bars

Home Environment

- stairs into house/ stairs in the house
- location of bathrooms

Family and Social History

Living Arrangement: apartment/house With Whom: Aide
Marital status: married/ widow/ single/other
Education:
Work History:
Finance/Will/POA:
Hobbies/Leisure:
Smoking (pack.year): Alcohol:
Family Hx of Dementia/depression/psychotic illness/PD/CVA.

Geriatric Review of Systems/Geriatric Syndromes:

1- Sphincter: Bladder/Continence, Bowel Function: Constipation/Continence
2- Gait/ walking aid/ Falls in the last year
3- Mood
4- Memory Impairment: Insight
5- Sensory: Vision-cataract Sx/ Glaucoma, Hearing loss/Hearing-aid
6- Appetite /Weight loss/dentures
7- Pain: site/severity/control/meds
8- Sleep: insomnia (early-late), other sleep disorders (RLS, RBD,..)
9- Neurologic: Dizziness/vertigo/syncope, weakness/numbness/tremor, headache, Diplopia/Dysarthria/Dysphagia
10- Pertinent cardiac and respiratory
11- Other pertinent positives

Mental Status Examination:

- ✓ Mini-cog test: (/5)
  Clock Drawing Test: (/3)
  MMSE (/30), MOCA (/30), RUDAS (/30)
- ✓ Geriatric Depression Scale (GDS): (/15)

- ✓ Appearance
  Affect
  Speech: Word finding difficulty/aphasia/Dysarthria
  Hallucinations/delusions
  Acquired knowledge and Judgment
  Insight

Physical Examination:

- ✓ General Observations: Pale/cyanotic/flushed/distressed
  Cachectic/other
- ✓ Vital signs:

BP	Supine /	Standing /
HR	Supine bpm	Standing bpm
Temp		
Weight	kg	Past visits' wt:

Head and Neck:
Chest:
Breast:
CVS:
Abdominal:
MSK:
Skin:
Neurological Examination:
Gait/ TUG test (sec)

Significant Test Results:-

B12	Ca	HbA1c
TSH	PO4	
PTH	Vit D	

CBC

Kft

Neuroimaging: CT/MRI

Last DEXA scan:

Recommendations:

Issues	Recommendations

Physicians Name/ Signature: ---------- PGY------