

# **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**

- HTN
- Dyslipidemia
- DM (OHA/Insulin)
- CAD/stents/CHF
- A.Fib/ Pacemaker
- Stroke/TIA
- Arthritis (OA, RA)
- Osteoporosis
- Thyroid
- Parkinson's
- Cancer
- Other

### **Past Psychiatric History**

- 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

Type of reaction

### **Functional Status (self-report)**

<b>1.ADLs</b>	Feeding	Independent	Supervised	Assisted	Dependent
	Dressing	Independent	Supervised	Assisted	Dependent
	Bathing	Independent	Supervised	Assisted	Dependent
	Toileting	Independent	Supervised	Assisted	Dependent
	Ambulation	Independent	Supervised	Assisted	Dependent
	Transfers/ Stairs	Independent	Supervised	Assisted	Dependent
	Praying	Independent	Supervised	Assisted	Dependent
<b>2.IADLs</b>	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
<b>3. AADLs:</b>	House-bound	Bed-bound	Out and about		

### **Home Safety Issues**

- leaves stove on/ water running.
- Wandering

### **Assistive Devices**

- Walker
- Cane
- Wheelchair
- 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:  
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:**

- 1- Sphincter: Bladder/Continence, Bowel Function: Constipation/Continence
- 2- Gait/ 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)  
Geriatric Depression Scale (GDS): ( /15)
- ✓ Appearance  
Affect  
Speech: Word finding difficulty/aphasia/Dysarthria  
Hallucinations/delusions  
Acquired knowledge  
Judgment  
Insight

## **Physical Examination:**

General Observations: Pale/cyanotic/flushed/distressed  
   Cachectic/other

Vital signs	BP	HR	RR
Supine			Temp
Sitting			Height
Standing			Weight

Head and Neck:

Chest:

Breast:

CVS:

Abdominal:

MSK:

Skin:

Neurological Examination:

Gait :

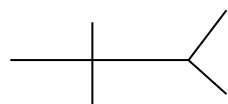
**Significant Test Results:-**

B12	Ca	HbA1c
TSH	PO4	
PTH	Vit D	

CBC



Kft



Neuroimaging: CT/MRI

Last DEXA scan:

**Recommendations:**

Issues	Recommendations

Physicians Name/ Signature: -----

PGY-----