

# 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 \_\_\_\_\_



## **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-----