Practical Geriatric Assessment

To be completed by the patient or caregiver

Patient Name:	Patient DOB:	Date Being Completed:

1 | How many times have you fallen in the last 6 months? _____

2 | Does your health limit you in walking one block?

- ☐ Not limited at all
- ☐ Limited a little
- ☐ Limited a lot

3 | Does your health now limit you in climbing one flight of stairs?

- ☐ Not limited at all
- ☐ Limited a little
- ☐ Limited a lot

4 | Can you get to places out of walking distance...

- ☐ Without help (drive your own car, or travel alone on buses or taxis);
- ☐ With some help (need someone to help you or go with you when traveling); or
- ☐ Are you unable to travel unless emergency arrangements are made for a specialized vehicle like an ambulance?

5 | Can you go shopping for groceries or clothes (assuming you have transportation)...

- ☐ Without help (taking care of all shopping needs yourself, assuming you had transportation);
- ☐ With some help (need someone to go with you on shopping trips); or
- ☐ Are you completely unable to do any shopping?

6 | Can you prepare your own meals...

- ☐ Without help (plan and cook all meals yourself);
- ☐ With some help (can prepare somethings but unable to cook full meals yourself); or
- ☐ Are you completely unable to prepare any meals?

7 | Can you do your housework...

- ☐ Without help (can clean floors, etc.);
- ☐ With some help (can do light housework but need help with heavy work); or
- ☐ Are you completely unable to do any housework?

8 | Can you take your own medicines...

☐ Without help (in the right doses at the right time);
☐ With some help (able to take medicine if someone prepares it for you and/or reminds you); or
☐ Are you completely unable to take your medicines?

9 | Can you handle your own money...

☐ Without help (write checks, pay bills, etc.);
☐ With some help (manage day-to-day buying but need help with managing your checkbook and paying your bills); or
☐ Are you completely unable to handle money?

10 | Can you get in and out of bed...

☐ Without any help or aids;
☐ With some help (either from a person or with the aid of some device); or
☐ Are you totally dependent on someone else to lift you?

11 | Can you dress and undress yourself...

☐ Without any help (able to pick out clothes, dress and undress yourself);
☐ With some help; or
☐ Are you completely unable to dress and undress yourself?

12 | Can you take a bath or shower...

☐ Without help;
☐ With some help (need help getting in and out of the tub or need special attachments); or
☐ Are you completely unable to bathe yourself?

13 | During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
☐	☐	☐	☐	☐

14 | How is your eyesight (with glasses or contacts)?

EXCELLENT	GOOD	FAIR	POOR	TOTALLY BLIND
☐	☐	☐	☐	☐

15 | How is your hearing (with a hearing aid, if needed)?

EXCELLENT	GOOD	FAIR	POOR	TOTALLY DEAF
☐	☐	☐	☐	☐

16 | Are you basically satisfied with your life? ☐ Yes ☐ No

Do you often get bored? ☐ Yes ☐ No

Do you often feel helpless? ☐ Yes ☐ No

Do you prefer to stay at home rather than going out and doing new things? ☐ Yes ☐ No

Do you feel pretty worthless the way you are now? ☐ Yes ☐ No

17 | KINDS OF SUPPORT Do you have...	NONE OF THE TIME	A LITTLE OF THE TIME	SOME OF THE TIME	MOST OF THE TIME	ALL OF THE TIME
Someone to help if you were confined to bed	☐	☐	☐	☐	☐
Someone to take you to the doctor if needed	☐	☐	☐	☐	☐
Someone to prepare your meals if you are unable to do it yourself	☐	☐	☐	☐	☐
Someone to help with daily chores if you were sick	☐	☐	☐	☐	☐
Someone to have a good time with	☐	☐	☐	☐	☐
Someone to turn to for suggestions about how to deal with a personal problem	☐	☐	☐	☐	☐
Someone who understands your problems	☐	☐	☐	☐	☐
Someone to love and make you feel wanted	☐	☐	☐	☐	☐

18 | IN THE PAST 7 DAYS...	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
I felt fearful	☐	☐	☐	☐	☐
I found it hard to focus on anything other than my anxiety	☐	☐	☐	☐	☐
My worries overwhelmed me	☐	☐	☐	☐	☐
I felt uneasy	☐	☐	☐	☐	☐

19 \| **Your Health:** Do you have any of the following illnesses **at the present time?**
If you fill in **"yes,"** please tell us how much the illness interferes with your activities:

ILLNESS	NO	YES	IF "YES" INTERFERES WITH ACTIVITIES	NOT AT ALL	SOMEWHAT	A GREAT DEAL
Other cancers or leukemia	☐	☐	→	☐	☐	☐
Arthritis or rheumatism	☐	☐	→	☐	☐	☐
Glaucoma	☐	☐	→	☐	☐	☐
Emphysema or chronic bronchitis	☐	☐	→	☐	☐	☐
High blood pressure	☐	☐	→	☐	☐	☐
Heart disease	☐	☐	→	☐	☐	☐
Circulation trouble in arms or legs	☐	☐	→	☐	☐	☐
Diabetes	☐	☐	→	☐	☐	☐
Stomach or intestinal disorders	☐	☐	→	☐	☐	☐
Osteoporosis	☐	☐	→	☐	☐	☐
Chronic liver or kidney disease	☐	☐	→	☐	☐	☐
Stroke	☐	☐	→	☐	☐	☐
Depression	☐	☐	→	☐	☐	☐

Practical Geriatric Assessment

To be completed by provider

Patient Name:	Patient DOB:	Date Being Completed:

Nutrition

How much weight have you lost in the past 3 months?

☐ No weight loss /less than 1 kg (2.2 lbs)
☐ Greater than 3 kg (6.6 lbs)
☐ Between 1 and 3 kg (2.2 and 6.6 lbs)
☐ Do not know the amount

Gait Speed

"Now I am going to observe how you normally walk. If you use a cane or other walking aid and you feel you need it to walk a short distance, then you may use it."

- "This is our walking course. I want you to walk to the other end of the course at your usual speed, just as if you were walking down the street to go to the store."
- Demonstrate the walk for the participant.
- "Walk all the way past the other end of the tape before you stop. I will walk with you. Do you feel this would be safe?"
- Have the participant stand with both feet touching the starting line.
- "When I want you to start, I will say: "Ready, begin."" When the participant acknowledges this instruction say: "Ready, begin."
- Press the start/stop button to start the stopwatch as the participant begins walking.
- Walk behind and to the side of the participant.
- Stop timing when one of the participant's feet is completely across the end line.

Time for Gait Speed Test (sec) **TIME FOR 4 METERS** ___ ___ . ___ sec

Mini-Cog

STEP 1: THREE WORD REGISTRATION

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move to step 2.

Version 1: Banana, Sunrise, Chair

Version 2: Leader, Season, Table

Version 3: Village, Kitchen, Baby

STEP 2: CLOCK DRAWING

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now set the hands to 10 past 11." Repeat instructions as needed as this is not a memory test. Move to step 3 if the clock is not complete within three minutes.

STEP 3: THREE WORD RECALL

Ask the person to recall the three words stated in step 1> Say: "What were the three words I asked you to remember?"

SCORING

Word Recall ___ (0-3 points)
1 POINT FOR EACH WORD RECALLED

Clock Draw ___ (0 or 2 points)
2 POINTS FOR NORMAL CLOCK, 0 IF ABNORMAL

Total Score: ___ (0 to 5 points)

Chemo-Toxicity

The patient's chemo-toxicity can be calculated using the Cancer and Aging Research Group's Chemo-Toxicity Calculator at mycarg.org. The patient's responses to questions 1, 2, 8, 13, and 15 should be used for corresponding questions in the calculator.