

**HOWARD UNIVERSITY COLLEGE OF MEDICINE
DIVISION OF GERIATRICS**

Patient's Name: _____
 Date / Time: _____
 Pharmacy No: _____
 Phone: _____

Examiner: _____
 D.O.B.: _____

HEALTH MAINTENANCE PROFILE

Problem List/Date of Onset	Date	Medications	Dose	Frequency	Comment
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Allergies																				
Immunizations																				
Pneumovax																				
Flu																				
Td																				
Others																				
PPD																				
PSA																				
Mammogram																				
PAP																				
Hemocult																				
TFT																				
Sigmoidoscopy																				

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Patient's Name: _____

PREVENTATIVE CHECKLIST

Comprehensive Evaluation Dates:														
Age at time of exam:														
ROS	Weight change													
	Mental Status													
	Hearing													
	Vision													
	Bowel													
	Urinary													
	Falls													
Physical Exam	BP													
	Weight													
	Vision													
	Hearing													
	Breast Exam													
	Pelvic													
	Prostate													
	Rectal													
	Gait/Balance													
Diagnostic Tests	Cholesterol													
	Stool Occult Blood													
	Audiogram													
	Mammogram													
	Sigmoidoscopy													
	Pap smear													
Counseling list	Diet													
	Vitamins													
	Exercise													
	Injury Prevention													
	Community resources													
	Medication Review													
Others														

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Patient's Name: _____

Date / Time: _____

Examiner: _____

HEALTH STATUS REVIEW

Indicate degree of dependence: 0=Independent; 1=Mild Dependency; 2=Moderate Dependency; 3=Severe Dependency

Functional Status	Baseline	Date	Date	Date	Date	Date	Date	Date	Date
Activities of Daily Living									
Dressing									
Feeding									
Continence									
Bathing									
Toileting									
Transfer									
Independent Activities of Daily									
Telephone									
Shopping									
Food Preparation									
Laundry									
Mode of Transportation									
Responsibility for own meds									
Manages finances									
Other Data									
Marital Status									
Occupation									
Living Arrangement									
Driving									
Smoking									
Alcohol									
Exercise									

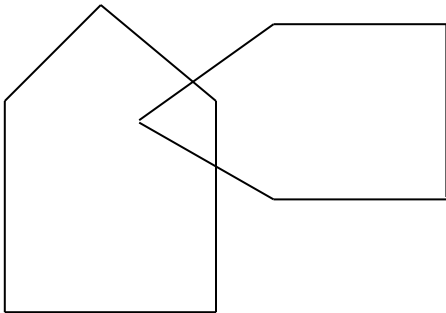
**HOWARD UNIVERSITY COLLEGE OF MEDICINE
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**MINI-MENTAL STATE EXAMINATION
CONTINUED FROM REVERSE**

CLOSE YOUR EYES

WRITE A SENTENCE

COPY DESIGN



Date	Score		Date	Score		Date	Score		Date	Score		Date	Score		Date	Score

**HOWARD UNIVERSITY COLLEGE OF MEDICINE
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Name: _____

Date: _____

Administered by: _____

DEPRESSION SCALE

The answers to these questions about how the patient felt over the past week should be elicited from the patient during the interview and entered by the investigator below:

	YES	NO
Are you basically satisfied with you life?	_____	_D_
Have you dropped many of your activities and interests?	_D_	_____
Do you feel your life is empty?	_D_	_____
Do you often get bored?	_D_	_____
Are you hopeful about the future?	_____	_D_
Are you bothered about thoughts you can't get out of your head?	_D_	_____
Are you in good spirits most of the time?	_____	_D_
Are you afraid that something bad is going to happen to you?	_D_	_____
Do you feel happy most of the time?	_____	_D_
Do you feel helpless?	_D_	_____
Do you often get restless and fidgety?	_D_	_____
Do you prefer to stay at home, rather than going out and doing new things?	_D_	_____
Do you frequently worry about the future?	_D_	_____
Do you feel that you have more problems with memory than most?	_D_	_____
Do you think it is wonderful to be alive now?	_____	_D_
Do you often feel downhearted and blue?	_D_	_____
Do you feel pretty worthless the way you are now?	_D_	_____
Do you worry a lot about the past?	_D_	_____
Do you find life exciting?	_____	_D_
Is it hard to get started on new projects?	_D_	_____
Do you feel full of energy?	_____	_D_
Do you feel that your situation is hopeless?	_D_	_____
Do you think that most people are better than you are?	_D_	_____
Do you frequently get upset over little things?	_D_	_____
Do you frequently feel like crying?	_D_	_____
Do you have trouble concentrating?	_D_	_____
Do you enjoy getting up in the morning?	_____	_D_
Do you prefer to avoid social gatherings?	_D_	_____
Is it easy for you to make decisions?	_____	_D_
Is your mind as clear as it used to be?	_____	_D_

This is the scoring for the scale: One point for each D answers. Cutoff: normal = 0 -9; mild depressives 10-19; severe depressive 20-30.

**HOWARD UNIVERSITY COLLEGE OF MEDICINE
DIVISION OF GERIATRICS**

Name: _____

Date: _____

Administered by: _____

NUTRITIONAL RISK INDEX

- | | | | |
|-----|---|-----|--------|
| 1. | Do you have an illness or condition that interferes with your eating? | YES | NO |
| 2. | Do you have an illness that has cut down on your appetite? | YES | NO |
| 3. | Do you have trouble biting or chewing any kind of food? | YES | NO |
| 4. | Are there any kinds of foods that you don't eat because they disagree with you? | YES | NO |
| 5. | Do you wear dentures? | YES | NO |
| 6. | Have you had any spells of pain or discomfort for 3 days or more in your abdomen or stomach in the past months? | YES | NO |
| 7. | Did you have any trouble swallowing at least 3 days in the last month? | YES | NO |
| 8. | Did you have any trouble with you bowels that make you constipated or give you diarrhea? | YES | NO |
| 9. | Do you have any trouble with your bowels that makes you constipated or gives you diarrhea? | YES | NO |
| 10. | Have you gained or lost any weight in the last 30 days?
(Note: net gain/loss must have exceeded 10 pounds.) | YES | NO |
| 11. | In the past month, have you taken any medicines prescribed by a doctor? | | YES NO |
| 12. | Have you ever been told by a doctor that you were "anemic"
(had iron poor blood)? | YES | NO |
| 13. | Do you smoke cigarettes regularly now? | YES | NO |
| 14. | Have you ever had an operation on your abdomen? | YES | NO |
| 15. | In the past month, have you taken any other medicines that were not prescribed by a doctor? | YES | NO |
| 16. | Are you now on any kind of a special diet? | YES | NO |

**HOWARD UNIVERSITY COLLEGE OF MEDICINE
DIVISION OF GERIATRICS**

Name: _____

Date: _____

Administered by: _____

ENVIRONMENTAL ASSESSMENT

1. How many rooms are available to patient?
 Own bedroom _____ If shared, with whom? _____
 Bathroom _____
 Kitchen _____
 Living/sitting room _____

2. Must patient climb stairs to enter or leave house?
 YES _____ NO _____

3. Is neighborhood dangerous?
 YES _____ NO _____

4. Is house clean?
 YES _____ NO _____

5. Does house seem adequately insulated and ventilated?
 YES _____ NO _____

6. Are there signs of neglect?
 Old food in refrigerator _____
 Unwashed dishes _____
 Accumulated dirty clothing _____
 Other (describe) _____

7. Is there a sufficient supply of food for at least several days?
 YES _____ NO _____

8. Safety checklist

	YES	NO
a. Can the patient		
Lock and unlock the door	___	___
Reach light switches	___	___
Call for help (telephone and numbers accessible)	___	___
Safely transfer from bed, chair, toilet, tub	___	___
b. Are there obvious dangers:		
Overloaded electrical wires	___	___
Frayed electrical wires	___	___
Poor lighting	___	___
Cluttered furniture	___	___
Unsafe furniture	___	___
Frayed carpets or broken floors	___	___
Missing or broken smoke alarm	___	___

**HOWARD UNIVERSITY HOSPITAL
DIVISION OF GERIATRICS**

Patient's name: _____

Date/Time: _____

Administered: _____

MICHIGAN ALCOHOLISM SCREENING TEST (MAST)

		Scoring Weights
1.	Do you feel you are a normal drinker?	N-2
2.	Have you ever awakened the morning after some drinking the night before and Found that you could not remember a part of the evening before?	Y-2
3.	Does your wife/husband/companion ever worry or complain about your drinking.	Y-1
4.	Can you stop drinking without a struggle after one or two drinks?	N-2
5.	Do you ever feel bad about your drinking?	Y-1
6.	Do friends or relatives think you are a normal drinker?	N-2
7.	Are you always able to stop drinking when you want to?	N-2
8.	Have you ever attended a meeting of Alcoholics/Anonymous (AA)?	Y-5
9.	Have you gotten into fights when drinking?	Y-1
10.	Has drinking ever created problems between you and your wife/husband?	Y-2
11.	Has your wife/husband (or other family member) ever gone to anyone for help about your drinking?	Y-2
12.	Have you ever lost friends or girlfriends because of your drinking?	Y-2
13.	Have you ever gotten into trouble at work because of drinking?	Y-2
14.	Have you ever lost a job because of drinking?	Y-2
15.	Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	Y-2
16.	Do you ever drink before noon?	Y-1
17.	Have you ever been told you have liver trouble? Cirrhosis?	Y-2
18.	Have you ever gone to anyone for help about your drinking?	Y-2
19.	Have you ever gone to anyone for help about your drinking?	Y-5
20.	Have you ever been to a hospital because of drinking?	Y-5
21.	Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was a part of the problem?	Y-2
22.	Have you ever been seen at a psychiatric or mental health clinic or gone to a Doctor, social worker or clergyman for help with an emotional problem in Which drinking has played a part?	Y-2

BALANCE

Instructions: Subject is seated in hard armless chair.
The following maneuvers are tested.

1.	Sitting balance	leans or slides in chair = 0 steady, safe = 1	<input style="width: 30px; height: 20px;" type="checkbox"/> 51	
2.	Arise	unable without help = 0 able but uses arm to help = 1 able without use of arms = 2	<input style="width: 30px; height: 20px;" type="checkbox"/> 52	
3.	Attempts to arise	unable without help = 0 able, but requires more than one attempt = 1 able to arise with one attempt = 2	<input style="width: 30px; height: 20px;" type="checkbox"/> 53	
4.	Immediate standing balance (first 5 seconds)	unsteady (staggers, moves feet marked trunk sway = 0 steady, but uses walker or cane or grabs other object for support = 1 without walker or cane or other support = 2	<input style="width: 30px; height: 20px;" type="checkbox"/> 54	steady
5.	Standing balance	unsteady = 0 steady, but wide stance (medial heels more than 4" apart) or uses cane, walker or other support = 1 narrow stance without support = 2	<input style="width: 30px; height: 20px;" type="checkbox"/> 55	
6.	Nudge (subject at maximum position with feet as close together as possible, examiner pushes lightly on subject's sternum with palm of hand 3 times.)	Begins to fall = 0 Staggers, grabs, but catches self = 1 Steady = 2	<input style="width: 30px; height: 20px;" type="checkbox"/> 56	
7.	Eyes closed (at maximum position #6)	unsteady = 0 steady = 1	<input style="width: 30px; height: 20px;" type="checkbox"/> 57	
8.	Turn 360 degrees	discontinuous steps = 0 continuous = 1 unsteady (grabs, staggers) = 0 steady = 1	<input style="width: 30px; height: 20px;" type="checkbox"/> 58 <input style="width: 30px; height: 20px;" type="checkbox"/> 59	
9.	Sit down	unsafe (misjudged distance; falls into chair) = 0 uses arms or not a smooth motion = 1 safe, smooth motion = 2	<input style="width: 30px; height: 20px;" type="checkbox"/> 60	

BALANCE SCORE: /16

GAIT

Instructions: Subject stands with examiner. Walks down hallway or across room, first at his/her “usual” pace, then back at “rapid, but safe” pace (using usual walking aid such as cane, walker).

- | | | | | |
|-----|--|-----|--------------------------|----|
| 10. | Initiation of gait (immediately after told to “go”) | | | |
| | any hesitancy or multiple attempts to start | = 0 | <input type="checkbox"/> | 61 |
| | no hesitancy | = 1 | | |
| 11. | Step length and height | | | |
| | a. Right swing foot | | | |
| | Does not pass L. stance foot with step | =0 | <input type="checkbox"/> | 62 |
| | Passes L. stance foot | =1 | | |
| | R. foot does not clear floor completely with step | =0 | <input type="checkbox"/> | 63 |
| | R. foot completely clears floor | =1 | | |
| | b. Left swing foot | | | |
| | Does not pass right stance foot with step | =0 | <input type="checkbox"/> | 64 |
| | Passes R. stance foot | =1 | | |
| | L. foot does not clear floor completely with step | =0 | <input type="checkbox"/> | 65 |
| | L. foot completely clears floor | =1 | | |
| 12. | Step symmetry | | | |
| | R. and L. step length not equal (estimate) | =0 | <input type="checkbox"/> | 66 |
| | R. and L. step appear equal | =1 | | |
| 13. | Step continuity | | | |
| | stopping or discontinuity between steps | =0 | <input type="checkbox"/> | 67 |
| | steps appear continuous | =1 | | |
| 14. | Path (estimated in relation to floor tiles, 12 inch diameter.
Observe excursion of one foot over about 10 feet of course) | | | |
| | Marked deviation | =0 | <input type="checkbox"/> | 68 |
| | Mild/moderate deviation or uses walking aid | =1 | | |
| | Straight without walking aid | =2 | | |
| 15. | Trunk | | | |
| | marked sway or uses walking aid | =0 | | |
| | no sway but flexion of knees or back or
spreads arms out while walking | =1 | <input type="checkbox"/> | 69 |
| | no sway, no flexion, no use of arms and no walking aid | =2 | | |
| 16. | Walk stance | | | |
| | Heels apart | =0 | <input type="checkbox"/> | 70 |
| | Heels almost touching while walking | =1 | | |

GAIT SCORE: /12

TOTAL SCORE: /28

PREDICTING PRESSURE SORE RISK

Patient's Name: _____

Evaluator's Name: _____

Date of Assessment _____

SENSORY PERCEPTION:	1. Completely limited:	2. Very limited:	3. Slightly limited:	4. No Impairment:
ability to respond meaningfully	Unresponsive (does not moan,	Responds only to painful stimuli.	Responds to verbal commands,	Responds to verbal

to pressure-related discomfort	flinch or gasp) the painful stimuli because of diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment that limits the ability to feel pain or discomfort over 1/2 of body.	but cannot always communicate discomfort or need to be turned. OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	commands. Has no sensory deficit that would limit pain or discomfort.	ability to feel or voice
MOISTURE:	1. Constantly Moist:	2. Very Moist:	3. Occasionally Moist:	4. Rarely Moist:	
degree to which skin is exposed to moisture	Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	Skin is often, but not always moist. Linen must be changed at least once a shift.	Skin is occasionally moist, requiring an extra linen change approximately once a day.	Skin is usually dry, linen only requires changing at routine intervals.	
ACTIVITY:	1. Bedfast:	2. Chairfast:	3. Walks Occasionally:	4. Walks Frequently:	
degree of physical activity	Confined to bed	Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	Walks occasionally during day, but for very short distances, with or without assistance. Spend majority of each shift in bed or chair.	Walks outside the room at least twice a day and inside room at least once every 24 hours during waking hours.	
MOBILITY:	1. Completely immobile:	2. Very limited:	3. Slightly Limited:	4. No Limitation:	
ability to change and control body position	Does not make even slight changes in body or extremity position without assistance.	Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	Makes frequent thought slight changes in body or extremity position independently.	Makes major and frequent changes in position without assistance.	
NUTRITION:	1. Very Poor:	2. Probably Inadequate:	3. Adequate:	4. Excellent:	
usual food intake pattern	Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement offered. OR is on a tube feeding or TPN regimen that probably meets most of nutritional needs.	Eats most of every meal. Never refuses a meal. Usually eats a total of 3-4 servings of meat or dairy products. Occasionally eats between meals. Does not require supplement.	
FRICITION AND SHEAR:	1. Problem:	2. Potential Problem:	3. No Apparent Problem:		
	Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spatiality, contractors, or agitation leads to almost constant friction.	Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		
<i>Adopted from: Braden Scale</i>					TOTAL SCORE