

# Advance Preventie Medicine

Label or  
Name \_\_\_\_\_  
DOB \_\_\_\_\_

## GERIATRIC SCREENING TOOL

Current Height: \_\_\_\_\_ Height at age 40: \_\_\_\_\_ Weight: \_\_\_\_\_

| PROBLEM                             | SCREENING MEASURE  | POSITIVE SCREEN   | COMMENTS  |
|-------------------------------------|--|---|---|
| <b>1. VISION</b>                    | Ask the question:<br>“Because of your eyesight, do you have trouble driving a car, watching television, reading or doing any of your daily activities?”<br>Or test with the Snellen Eye chart.   | “Yes” to question.<br>Or, inability to read at better than 20/40 on the Snellen eye chart.  | <input type="checkbox"/> Positive <input type="checkbox"/> Negative<br><input type="checkbox"/> Ophthalmology Referral<br><input type="checkbox"/> _____<br><input type="checkbox"/> Performed at another time, see progress note dated _____   |
| <b>2. HEARING</b>                   | Ask the patient:<br>“Have you ever been embarrassed about your hearing? Do you have trouble hearing whispers? Do you have trouble hearing at the movies, in theaters, or at religious functions? Does your hearing lead to arguments with your family? Do you have trouble hearing particular voices among all the ‘hubbub’ in restaurants?” | “Yes” to any question.<br>Or, inability to repeat correctly 50% of whispered words.<br>Or, inability to hear 1000 or 2000 Hz in both ears and inability to hear both frequencies in either ear. | <input type="checkbox"/> Positive <input type="checkbox"/> Negative<br><input type="checkbox"/> ENT Referral<br><input type="checkbox"/> Audiometry<br><input type="checkbox"/> Hearing Aid<br><input type="checkbox"/> _____<br><input type="checkbox"/> Performed at another time, see progress note dated _____                      |
| <b>3. LEG MOBILITY</b>              | Time the patient after giving these directions:<br>“Rise from the chair. Then walk 10 feet briskly, turn, walk back to the chair and sit down”.  | Unable to complete task in 15 seconds.  | <input type="checkbox"/> Positive <input type="checkbox"/> Negative<br><input type="checkbox"/> Fall Prevention Referral<br><input type="checkbox"/> P.T. Consult<br><input type="checkbox"/> Assistive Device<br><input type="checkbox"/> _____<br><input type="checkbox"/> Performed at another time, see progress note dated _____   |
| <b>4. URINARY INCONTINENCE</b>      | Ask this question:<br>“In the past year, have you ever lost control of your urine.”  | “Yes” to this question.   | <input type="checkbox"/> Positive <input type="checkbox"/> Negative<br><input type="checkbox"/> Schedule Pelvic Exam<br><input type="checkbox"/> Urodynamic Studies<br><input type="checkbox"/> Urology Referral<br><input type="checkbox"/> _____<br><input type="checkbox"/> Performed at another time, see progress note dated _____ |
| <b>5. NUTRITION AND WEIGHT LOSS</b> | Ask this question:<br>“ Have you lost 10 lbs. over the past six months without trying to do so?”<br>AND review weights in the chart from the past 6 months.  | “Yes” to the question or a weight loss of > 5%.   | <input type="checkbox"/> Positive <input type="checkbox"/> Negative<br><input type="checkbox"/> Social Work Referral<br><input type="checkbox"/> Dietary Consult<br><input type="checkbox"/> _____<br><input type="checkbox"/> Performed at another time, see progress note dated _____   |
| <b>6. MEMORY</b>                    | Three item recall.<br>Or, the Folstein’s Mini-Mental Exam`.  | Unable to remember all three items after one minute or a score of less than 25 on the MMSE.   | <input type="checkbox"/> Positive <input type="checkbox"/> Negative<br><input type="checkbox"/> Dementia Work-Up<br><input type="checkbox"/> _____<br><input type="checkbox"/> Performed at another time, see progress note dated _____   |

| <b>PROBLEM</b>   | <b>SCREENING MEASURE</b>   | <b>POSITIVE SCREEN</b>  | <b>COMMENTS</b>   |
|--|--|---|---|
| <b>7. DEPRESSION</b>   | Ask this question:<br>“Do you often feel sad or depressed?”  | “Yes” to the question, and/or meets DSM IV criteria.                                    | <input type="checkbox"/> Positive <input type="checkbox"/> Negative<br><input type="checkbox"/> Psych Referral<br><input type="checkbox"/> _____<br><input type="checkbox"/> Performed at another time, see progress note dated _____       |
| <b>8. ACTIVITIES OF DAILY LIVING AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING</b> | Ask the patient these six questions:<br>1. “Are you able to go shopping for groceries or clothes?”<br>2. “Are you able to bathe—sponge bath, tub bath or shower?”<br>3. “Are you able to dress yourself: such as put on a shirt; button and zip your clothes; or put on your shoes?”<br>4. “Are you able to handle your own finances?”<br>5. “Are you able to make your own meals?”<br>6. “Are you able to climb the stairs in your home?” | If the patient answers no to any of these questions AND they do not have adequate help. | <input type="checkbox"/> Positive <input type="checkbox"/> Negative<br><input type="checkbox"/> Social Work Referral<br><input type="checkbox"/> _____<br><input type="checkbox"/> Performed at another time, see progress note dated _____ |
| <b>9. Metabolic Syndrome</b>   | Any symptoms of metabolic syndrome or cardiovascular risks   |   |   |

**Performed by:**

**Reviewed by:**

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Clinician Signature/Date