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AMERICAN SOCIETY OF CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

CARG
Cancer & Aging Research Group

SIOG
INTERNATIONAL SOCIETY OF GERIATRIC ONCOLOGY

# 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 | ☐ | ☐ | → | ☐ | ☐ | ☐ |

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# 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.