Details of Section 2 of CGA- History Taking

A. Chief Complaint

1. .....

2. .....

3. .....

4. .....

5. .....

B. Details of complaints:

B1. Do you have any eye complaints?		Yes/No
If Yes, have you consulted any doctor for this problem?		Yes/No
Do you use spectacles?		Yes/No
If Yes, mention the power of the lens. Right Eye: Left Eye:		
Eye Symptoms	Response	Duration
Diminished Vision (Near/Distant)	Yes/No	
Visual blurring/Double vision/Distorted vision (straight lines become crooked/magnified/diminished)	Yes/No	
Pain in the eye	Yes/No	
Itching/foreign body sensation in the eye/Burning/Stinging sensation	Yes/No	
Discharge from eyes	Yes/No	
Any Other, specify:		

B2. Do you have any complaints related to Ear-Nose-Throat?		Yes/No
If Yes, have you consulted any doctor for this problem?		Yes/No
ENT Symptoms	Response	Duration
Earache	Yes/No	
Ear Discharge	Yes/No	
Hearing Loss	Yes/No	
Tinnitus (ringing, rushing or hissing sound in the absence of any external sound)	Yes/No	
Dizziness/Vertigo	Yes/No	
Hoarseness of voice (Sudden or Gradual)		

Nasal Discharge		
Any other, specify:		

B3. Do you have any complaints related to oro-dental condition?		**Yes/No**
If Yes, have you consulted any doctor for this problem?		**Yes/No**
Oro-dental Symptoms	Response	**Duration**
Bad Breath	Yes/No	
Visible pits or holes in the teeth/loose teeth	Yes/No	
Aggravation of pain with exposure to heat, cold or sweet foods and drinks	Yes/No	
Red swollen gums, tender and bleeding gums	Yes/No	
Ulcer/Sore in the mouth that does not health/Red or white patches inside the mouth	Yes/No	
Difficulty in opening the mouth	Yes/No	
Pain while swallowing	Yes/No	
Any other, specify		

B4. Do you have any cardiac or respiratory symptoms?		**Yes/No**
If Yes, have you consulted any doctor for this problem?		**Yes/No**
Cardio-Respiratory Symptoms	Response	**Duration**
Breathlessness	Yes/No	
Cough Expectoration	Yes/No	
Presence of blood in cough	Yes/No	
Noise coming from chest (audible wheeze)	Yes/No	
Chest pain	Yes/No	
Any other, specify:		

B5. Do you have any Gastro-intestinal Symptoms		**Yes/No**
If Yes, have you consulted any doctor for this problem?		**Yes/No**
Gastro-Intestinal Symptoms	Response	**Duration**
Difficulty in swallowing	Yes/No	
Heartburn	Yes/No	
Indigestion	Yes/No	
Constipation/Diarrhoea/Alteration of bowel pattern	Yes/No	
Abdominal pain/distension	Yes/No	
Bleeding during or after defecation		
Any other, specify:		

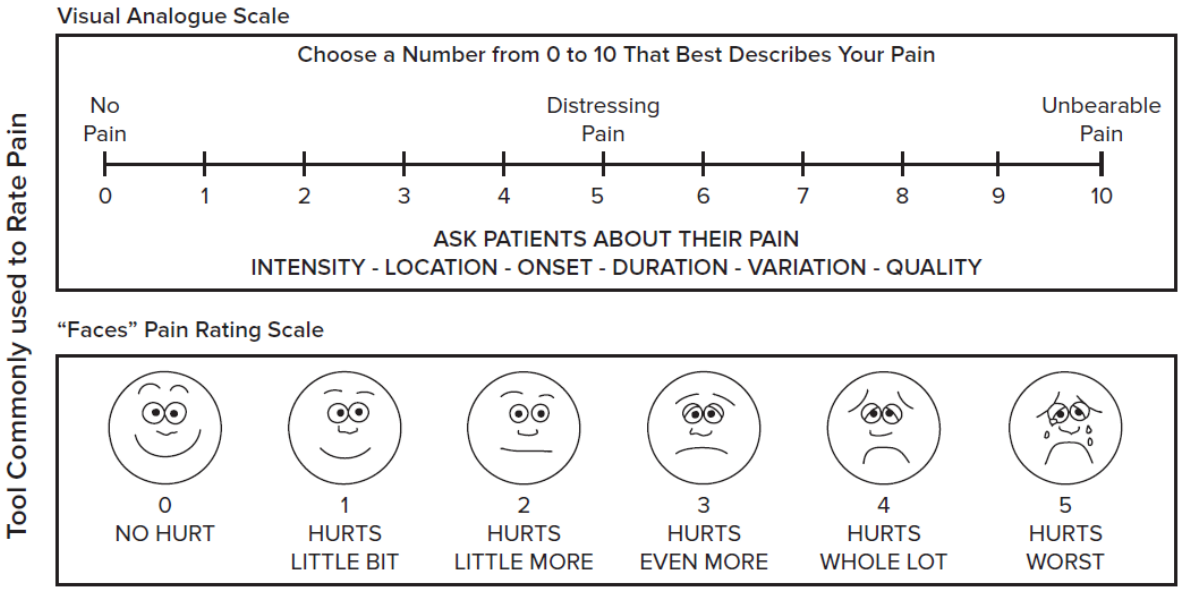
B6. Do you have any Genito-urinary complaints?		Yes/No
If Yes, have you consulted any doctor for this problem?		Yes/No
Genito-urinary Symptoms	Response	Duration
Pain in the lower part of the belly	Yes/No	
Pain or burning sensation while passing time	Yes/No	
Do you have to repeatedly visit washroom to pass urine?	Yes/No	
Difficulty in initiating urination	Yes/No	
Passing urine while coughing or sneezing	Yes/No	
Discharge from external genital region	Yes/No	
Any other, specify:		

B7. Do you have any skin related problems?		Yes/No
If Yes, have you consulted any doctor for this problem?		Yes/No
Skin related Symptoms	Response	Duration
Itching	Yes/No	
White/light coloured patches	Yes/No	
Dark/coloured patches	Yes/No	
Ulceration/Soreness/open wound	Yes/No	
Skin eruptions filled with fluid	Yes/No	
Any other, specify:		

B8. Dou you have any complaints suggestive of neurological problem?		Yes/No
If Yes, have you consulted any doctor for this problem?		Yes/No
Neurological Symptoms	Response	Duration
Increased difficulty in remembering	Yes/No	
Headache	Yes/No	
Loss of awareness regarding time, place and person	Yes/No	
Loss of balance/falls/weakness	Yes/No	
Involuntary movements of parts of body-tremors/inability to control limbs	Yes/No	
Pain/altered sensation	Yes/No	
Any other, specify:		

B9. Do you have any complaints related to muscles, bones or joints?		Yes/No
If Yes, have you consulted any doctor for this problem?		Yes/No
Musculo-skeletal symptoms	Response	Duratio

		n
Pain or stiffness in muscles, joints or back	Yes/No	
Any swelling in joints?	Yes/No	
Difficulty in carrying out normal activities	Yes/No	
Difficulty in walking up and down stairs	Yes/No	
Any other, specify:		



NOTE: Ask Females Only **B10. Do you have any gynecological symptoms?**		**Yes/No**
If Yes, have you consulted any doctor for this problem?		**Yes/No**
Gynecological Symptoms	Response	**Duration**
Bleeding per vagina	Yes/No	
Discharge per vagina	Yes/No	
Swelling/mass felt at the genital region	Yes/No	
Pain in the lower part of the belly	Yes/No	
Any history of surgical removal of womb (hysterectomy)?	Yes/No	
Have you ever been screened for: A) **Breast Cancer/SBE/Memmogram** B) **Cervical Cancer/VIA-VILI/Colposcopy/PAP SMEAR**	Yes/No	
Any other, specify:		

C. Past medical History

Is on treatment for	Duration of illness	Current medication & dosage	Verification of records	In case of treatment completion or stoppage, mention since how long
Diabetes Mellitus			Yes/No	
Hypertension			Yes/No	
Thyroid Disease			Yes/No	
Chronic Kidney Disease			Yes/No	
Tuberculosis			Yes/No	
Any other respiratory disease, specify.....			Yes/No	
Cardiac condition Specify.....			Yes/No	
Musculoskeletal condition Specify.....			Yes/No	
Neurological Condition Specify.....			Yes/No	
Psychiatric Disorder Specify.....			Yes/No	
Dental disorder Specify.....			Yes/No	
Any other condition Specify.....			Yes/No	
Has any vaccine taken during the past 5 years? Yes/No. If Yes, please specify: **Vaccine..... Date received.....** **Vaccine..... Date received.....** **Vaccine..... Date received.....**				
History of recent hospitalization (previous one year): **Yes/No If yes, specify the reasons below:**				

D. Drug History

S No.	QUESTION	RESPONSE (tick appropriate answer wherever applicable)
1	Are you taking any medication?	**Yes/NO If Yes,** **No. Of medicines taken daily:**
2	Are you taking any medications without consulting the doctor?	**Yes/No If Yes, Nmae the condition for which medicine is being taken:**
3	Are you suffering from any drug side effects?	**Yes/No If Yes, please specify:**
4	Are you taking any medicines other than allopathy?	**Ayurveda/Homeopathy/Unani/ Any other/None**
5	**Do you use a pill organizer?**	**Yes/No**

E. Consumption of additive substances

Additive Substances (tick 'Y' for yes and 'N' for no)		If yes, specify duration (in weeks or months or years)	Standard quantity	Quantity consumed (Fill any one)	If stopped, specify duration since last consumption
Tobacco					
Smokeless & chewable (Eg. gutka, khaini, paan masala, zarda, betel quid)	Y/N		No. Of packets	Per day... OR Per week....	
				OR	
				Per Month...	
				OR	
				Occasionally	
Snuff	Y/N			Per day... OR Per week.... OR Per Month... OR Occasionally	
Smoking (Eg. Cigarette, beedi, cigar, hookah)	Y/N		No. Of pieces/ packets	Per day... OR Per week....	
				OR	

				Per Month...	
				OR	
				Occasionally	

Additive Substances (tick 'Y' for yes and 'N' for no)		If yes, specify duration (in weeks or months or years)	Standard quantity	Quantity consumed (Fill any one)	If stopped, specify duration since last consumption
Alcohol	Y/N		One small peg= 30ml	Per day... OR	
				Per week....	
				OR	
				Per Month...	
				OR	
				Occasionally	
Opioids ('Afeem' or 'Doda' or 'Amal')	Y/N			Per day... OR	
				Per week....	
				OR	
				Per Month...	
				OR	
				Occasionally	
Sleeping pills	Y/N		No. of pills	Per day... OR Per week.... OR Per Month... OR Occasionally	
Painkillers	Y/N		No. of pills	Per day... OR Per week.... OR Per Month... OR Occasionally	

Cannabis (Ganja/Bhang)	Y/N			Per day... OR Per week.... OR Per Month... OR Occasionally	
Any other, specify:					

F. Nutritional History

Complete the screening by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Screening
A Has food intake declined declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? **0 = severe decrease in food intake** **1 = moderate decrease in food intake** **2 = no decrease in food intake** ☐
B Weight loss during the last 3 months **0 = weight loss greater than 3 kg (6.6 ibs)** **1 = does not know** **2 = weight loss between 1 and 3 kg (2.2 and 6.6)** **3 = no weight loss** ☐
C Mobility **0 = bed or chair bound** **1 = able to get out of bed / chair but does not go out** **2 = goes out** ☐
D Has suffered psychological stress or acute disease in the past 3 month? **0 = yes** **2 = no** ☐
E Neuropsychological problems **0 = severe dementia or depression** **1 = mild dementia** **2 = no psychological problems** ☐

F1 Body Mass Index (BMI) (weight in kg) / (height in m)^2

0 = BMI less than 19

1 = BMI 19 to less than 21

2 = BMI 21 to less than 23

3 = BMI 23 or greater

IF BMI IS NOT AVAILABLE, REPLACE QUESTION F1WITH QUESTION F2.
DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

F2 Calf circumference (CC) in

cm 0 = CC less than 31

3 = CC 31 or greater ☐

Screening score (max. 14 points) ☐☐

12-14 points: ☐ **Normal nutritional status**

8-11 points: ☐ **At risk of malnutrition**

0-7 points: ☐ **Malnourished**

Nutritional Diversity

Food item	Examples	Frequency of consumption (tick the appropriate answer)		Remarks
		Daily	weekly	
Cereals	Wheat, wheat flour (atta/ maida), rice (brown/white), rice flakes (chiwra), maize/ corn, barley, oats, suji, vermicelli (sevian), puffed rice, etc			
Millets	Bajra, Ragi, Jowar			
Pulses	Bengal gram (channa dal), Bengal gram flour (besan), green gram (moong dal), black gram (urad dal), arhar dal (tur dal) chickpea (white/black/green chana), sprouted pulses, legumes like rajma, lobia, soyabean and its products, etc.			

Vegetables and fruits	Green leafy vegetables - spinach, mustard leaves (sarson), fenugreek leaves, bathua, coriander leaves etc; Other vegetables - carrots, onion, brinjal, ladies finger, cucumber, cauliflower, tomato, capsicum, cabbage etc; **Starchy roots and tubers - potatoes, sweet potatoes, yam, colocasia and other root vegetables; Fruits - Mango, guava, papaya, orange, sweet lime, watermelon, lemon, grapes, amla, etc			
Milk	Milk, curd, skimmed milk, cheese, cottage cheese (paneer), etc			
Animal products	Meat, egg, fish, chicken, liver, etc.			
Oils, Fats, Sugar and Nuts	**Oils and Fats - Butter, ghee, vegetable cooking oils like groundnut oil, mustard oil, coconut oil, etc; Sugars - Sugar, jaggery, honey; Nuts - peanuts, almonds, cashew nuts, pistachios, walnuts, etc.**			

Ask the following questions:

a. Number of meals taken per dayVeg/Non Veg, Frequency of Non Veh..
b. Quantity of water/juice and other fluid consumed per day (in litres/in glasses)..
c. History of loss of weight (e.g. Loosening of clothes) Yes/No
d. If weight loss present, mention how much weight was lost in the past one month..
e. History of reduced appetite: Yes/No (If yes, give reason)
f. Difficulty in chewing food: Yes/No (If yes, give reason)
g. Difficulty in swallowing food: Yes/No (If yes, give reason)
h. Does the elderly person feed with some assistance: Yes/No
i. Consumption of additional sources of salt (e.g. Pickle, chutney, papad, ready to eat food): Yes/No (If Yes, specify:
j. Who prepares the food at home? (self/daughter/daughter in law/any other caregiver)

G. Family History:

Hypertension	Diabetes	Heart Disease	Dementia	Cancer

H a. Family support

Married:	Yes	No
Spouse living	Yes	**No**
Living with		
No of Children		
How often do you see them?		
Who assists you?		
Is the assistance sufficient?	Yes	**No**
Native Language		
Type of House	Independent	**Apartment**
Stairs	Present	**Absent**
Who would be able to help the senior citizen of your family in case of illness or emergency?		

H b. Social and Spiritual assessment

- Do you pray, worship or meditate at home or outside? Yes/No If yes, specify
- Do you participate in family or community gatherings? Yes/No If yes, specify
- Do you have any hobbies? Yes/No If yes, specify_

I. Personal History

- Do you exercise daily? Yes/ No
- If yes, minutes/day?

What type?		
Smoker	Yes	**No**
	Duration	
Alcohol	Yes	**No**
	Duration	

Caregiver fatigue	Yes	No

J. Home safety Environment

- Ask the senior citizen if he/she has trouble with lighting or with stairs inside or outside the house? Yes/No

Healthcare worker to assess the following:

Assessment	Observation (tick the appropriate answer)

Is the bathroom slippery and wet?	**Yes/No/Not applicable**
Is there any provision for a caregiver at home?	**Yes/No/Not applicable**
Is there any ramp at home for elderly using walking aids or wheelchairs?	**Yes/No/Not applicable**
Are there any handrails in the staircase and bathrooms?	**Yes/No/Not applicable**