**Yesavage Geriatric Depression Scale (GDS) – Short Form**

1. Are you basically satisfied with your life?  
   **YES / NO**

2. Have you dropped many of your activities and interests?  
   **YES / NO**

3. Do you feel that your life is empty?  
   **YES / NO**

4. Do you often get bored?  
   **YES / NO**

5. Are you in good spirits most of the time?  
   **YES / NO**

6. Are you afraid that something bad is going to happen to you?  
   **YES / NO**

7. Do you feel happy most of the time?  
   **YES / NO**

8. Do you often feel helpless?  
   **YES / NO**

9. Do you prefer to stay at home, rather than going out and doing new things?  
   **YES / NO**

10. Do you feel you have more problems with memory than most?  
    **YES / NO**

11. Do you think it is wonderful to be alive now?  
    **YES / NO**

12. Do you feel pretty worthless the way you are now?  
    **YES / NO**

13. Do you feel full of energy?  
    **YES / NO**

14. Do you feel that your situation is hopeless?  
    **YES / NO**

15. Do you think that most people are better off than you are?  
    **YES / NO**

<table>
<thead>
<tr>
<th>Score</th>
<th>NORMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>Normal</td>
</tr>
<tr>
<td>2-4</td>
<td>Mildly depressed</td>
</tr>
<tr>
<td>5-6</td>
<td>Very depressed</td>
</tr>
</tbody>
</table>

Adapted from Sheikh & Yesavage: *Clin Gerontol* 5:165, 1986
PATIENTS APPROPRIATE FOR HOUSE CALLS:

Require special transportation
Behaviorally difficult
Terminally ill / Home hospice
Caregiver burnout issues
Elder abuse / neglect in question
Chronic office “no shows”
Follow-up of recent hospitalization
Frequent falling
Recurrent medication nonadherence
Newborn visits

CONTENTS OF THE HOUSE CALL BAG

Sphygmomanometer
   Stethoscope
   Otoscope
   Ophthalmoscope
   Tongue depressor
Hemocult cards and developer
   Gloves
   Toe nail clippers
   Surgilube
   Prescription pads
   Sterile specimen cup
Blood draw supplies and tubes
   4x4 gauze and tape
   alcohol wipes

OPTIONAL/SEASONAL

   Pulse Oximeter
   Portable EKG machine
   Foley catheter kit
   Influenza vaccine
   Pneumovax
   Tetanus
   B12 injections
   Childhood vaccines
   Culturettes
   Scale

ELEMENTS OF THE GERIATRIC HOUSE CALL

Medical H & P as appropriate
Cognitive Assessment – MMSE, Judgment questions, GDS
Functional Assessment
   - Observe ambulation in home
      ○ Ask patient to give you a tour of home
   - Assess bathroom for grab bars, slip/fall hazards
   - Talk with other members of the household about functional concerns
Medication Assessment
   - Appropriate temperature
   - Cleanliness / Pets
   - Throw rugs
   - Lighting
   - Barriers to walkers, canes, wheelchairs
   - Security
   - Emergency contact information
Nutritional Assessment
   - Food availability (refrigerator and cabinet survey)
Brief Pain Inventory (Short Form)

Date: __/__/____
Name: ____________________________
Last: ____________________________ First: ____________________________ Middle Initial: ____________________________

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
   1. Yes
   2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.
   0  1  2  3  4  5  6  7  8  9  10
   No Pain Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its least in the last 24 hours.
   0  1  2  3  4  5  6  7  8  9  10
   No Pain Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the average.
   0  1  2  3  4  5  6  7  8  9  10
   No Pain Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have right now.
   0  1  2  3  4  5  6  7  8  9  10
   No Pain Pain as bad as you can imagine
7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

<table>
<thead>
<tr>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Relief</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

<table>
<thead>
<tr>
<th>A. General Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Mood</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Walking Ability</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Normal Work (includes both work outside the home and housework)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>E. Relations with other people</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
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</tbody>
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<table>
<thead>
<tr>
<th>F. Sleep</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G. Enjoyment of life</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

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Pain Research Group
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Patient Name:  
Examiner:  
Date:  
Time:  
Location:  
Respondent if other than patient (name and relation):  

1. General Health:  
   "How would you describe your health?"  
   Excellent / Good / Fair / Poor  

2. Activities of Daily Living  
   "Are you independent (I), require assistance (A), or dependent  
   (D) with each of the following tasks?"  

<table>
<thead>
<tr>
<th>ADL</th>
<th>Ambulating</th>
<th>I</th>
<th>A</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td>I</td>
<td>A</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td>I</td>
<td>A</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td>I</td>
<td>A</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td>I</td>
<td>A</td>
<td>D</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IADL</th>
<th>Using Telephone</th>
<th>I</th>
<th>A</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traveling</td>
<td>I</td>
<td>A</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Shopping</td>
<td>I</td>
<td>A</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Preparing Meals</td>
<td>I</td>
<td>A</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Housework</td>
<td>I</td>
<td>A</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Taking Medications</td>
<td>I</td>
<td>A</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Managing Finances</td>
<td>I</td>
<td>A</td>
<td>D</td>
<td></td>
</tr>
</tbody>
</table>

3. Geriatric Review of Systems  
   Vision: "Do you have difficulty driving, watching TV,  
   reading, or walking because of poor eyesight?"  
   YES  
   NO  

   Hearing: Can the patient hear normal conversation voice?  
   YES  
   NO  

   Memory: 3 item recall after 5 minutes (pony, quarter, orange)  
   RECALLED ________  
   NO
3. Geriatric Review of Systems (continued)

Depression: “Do you often feel sad or depressed?”
   YES      NO

Nutrition: “Have you unintentionally lost weight in the last 6 months?”
   YES      NO

Incontinence:
   “Do you have trouble with control of your bladder?”
      YES      NO
   “Do you have trouble with control of your bowels?”
      YES      NO

Falls: How many falls have you had in the past year? _____

Alcohol: “Do you drink alcohol?”
   YES      NO
   If yes, “How many drinks per week?” ________

1. Social Supports:
   “Do you live with anyone?”
      YES      NO
   Spouse / Child / Other Relative / Friend
   “Who would help you in an emergency?”

2. Polypharmacy:
   “How many medicine do you take including prescribed, over-the-counter and vitamins?”

   “What is your system for taking your medicines?”
   Pill Box / Family help / List or chart / None

3. Elder Abuse: “Has anyone intentionally tried to harm you?”
   YES      NO

4. Immunizations:
   “Did you receive the flu shot?” (for the current or most recent season)
      YES      NO
   “Have you received a Pneumovax shot?”
      YES      NO

Heppard /October 2001