Saint Louis University Division of Geriatrics

Passport to Aging Successfully*

Please complete this questionnaire before seeing your physician and take it with you when you go.

SAINT LOUIS UNIVERSITY

NAME _____ **AGE** _____

BLOOD PRESSURE laying down: _____ standing: _____

WEIGHT now: _____ 6 months ago: _____ change: _____

HEIGHT at age 20: _____ now: _____

CHOLESTEROL LDL: _____ HDL: _____

VACCINATIONS ☐Influenza (yearly) ☐Pneumococcal ☐Tetanus (every 10 years)

TSH Date: _____ **FASTING GLUCOSE** Date: _____

Do you SMOKE? _____

How much ALCOHOL do you drink? _____ per day

Do you use your SEATBELT? _____

Do you chew TOBACCO? _____

EXERCISE: How often do you...

do endurance exercises (walk briskly 20 to 30 minutes/day or climb 10 flights of stairs) _____/week

do resistance exercises? _____/week do balance exercises? _____/week

do posture exercises? _____/week do flexibility exercises? _____/week

Can you SEE ADEQUATELY in poor light? _____

Can you HEAR in a noisy environment? _____

Are you INCONTINENT? _____

Have you a LIVING WILL or durable POWER OF ATTORNEY FOR HEALTH? _____

Do you take ASPIRIN daily (only if you have had a heart attack or have diabetes)? _____

Do you have any concerns about your PERSONAL SAFETY? _____

When did you last have your STOOL TESTED for blood? _____

When were you last screened for OSTEOPOROSIS? _____

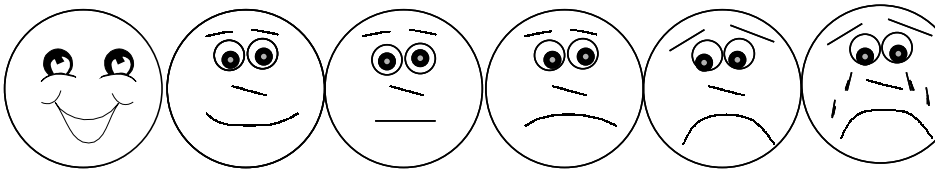
Are you having trouble REMEMBERING THINGS? _____

Do you have enough FOOD? _____

Are you SAD? _____

Do you have PAIN? _____

If so, which face best describes your pain?



0 1 2 3 4 5

MALES

Do you have trouble passing urine? _____

Have you discussed PSA testing with your doctor? _____

What is your ADAM score? _____

FEMALES

When was your last pap smear? _____

When was your last mammogram? _____

Do you check your breasts monthly? _____

Are you satisfied with your sex life? _____

Now, please answer the four questionnaires on the next page.

* This questionnaire is based on the health promotion and prevention guidelines developed by Gerimed® and Saint Louis University Division of Geriatric Medicine.

Passport to Aging Successfully

Please fill out these forms before seeing your physician and take them with you when you go.

Geriatric Depression Scale	**(circle one)**
Are you basically satisfied with your life?	YES NO
Have you dropped many of your activities and interests?	YES NO
Do you feel that your life is empty?	YES NO
Do you often get bored?	YES NO
Are you in good spirits most of the time?	YES NO
Are you afraid that something bad is going to happen to you?	YES NO
Do you feel happy most of the time?	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 you have more problems with memory than most?	YES NO
Do you think it is wonderful to be alive?	YES NO
Do you feel pretty worthless the way you are now?	YES NO
Do you feel full of energy?	YES NO
Do you feel that your situation is hopeless?	YES NO
Do you think that most people are better off than you are?	YES NO

Sheikh JI, Yesavage JA. Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. *Clinical Gerontologist* 1986;5:165.

CAGE

Have you ever considered **C**utting down on your alcohol intake? _____

Do people **A**nnoy you by criticizing your drinking? _____

Have you ever felt bad or **G**uilty about your drinking? _____

Have you ever had an alcoholic drink first thing in the morning (**E**yeopener) to steady your nerves or get rid of a hangover? _____

ADAM (Men only)

1. Do you have a decrease in libido? _____
2. Do you have a lack of energy? _____
3. Do you have a decrease in strength and/or endurance? _____
4. Do you have a decreased enjoyment of life? _____
5. Are you sad? _____
6. Are you grumpy? _____
7. Are your erections less strong? _____
8. Have you noticed a recent deterioration in your ability to play sports? _____
9. Are you falling asleep earlier after dinner? _____
10. Has there been a recent deterioration in your work performance? _____

Epworth Sleepiness Questionnaire

How likely are you to doze off or to fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Use the following scale to choose the most appropriate number for each situation.

0–would never doze	1–slight chance of dozing
2–moderate chance of dozing	3–high chance of dozing

Situation	**Chance of dozing**
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
As a passenger in a car for an hour	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car while stopped for a few minutes	
Total	____ / 24