Geriatric Nursing Assessment Form

I. Patient Demographics

Name
Age
Gender
Date of Assessment
Address
Contact Number
Next of Kin / Caregiver
Marital Status
Language Spoken

II. Medical History

Condition	Yes/No	Details
Hypertension		
Diabetes		
Cardiovascular disease		
Respiratory disease (e.g. COPD)		
Stroke		
Cancer		
Vision/Hearing issues		
History of falls		Date of last fall:
Incontinence (Urinary/Bowel)		
Polypharmacy (5+ meds)		List of current medications:

III. Mental & Cognitive Assessment

Tool/Question	Score/Observation
(Delirium screening)	
Geriatric Depression Scale	
Orientation (Time, Place, Person)	
Behavior or Mood Changes	
Sleep disturbances	

IV. Functional Assessment (ADLs)

Activity	Independent	Needs Help	Dependent
Bathing			

Activity	Independent	Needs Help	Dependent
Dressing			
Eating			
Toileting			
Transferring (bed/chair)			
Continence			

V. Instrumental Activities (IADLs)

Activity	Independent	Needs Help	Dependent
Using telephone			
Shopping			
Food preparation			
Housekeeping			
Laundry			
Transportation			
Medication management			
Managing finances			

VI. Physical Assessment

Parameter	Value/Observation
Blood Pressure	
Heart Rate	
Respiratory Rate	
Temperature	
Weight	
Height	
BMI	
Skin Integrity	
Vision/Hearing	
Oral health	
Foot condition	

VII. Risk Assessment

Risk Factor	Yes/No	Comments
Risk of Falls		
Pressure ulcer risk (Braden Scale)		
Nutritional risk (MUST Score)		
Abuse/Neglect suspected		

VIII. Social & Environmental

Factor	Details
Living arrangement	Alone / With family / Care facility

Factor	Details
Primary caregiver	
Financial status	Stable / Unstable
Access to health services	Yes / No
Social support	Strong / Limited / None
Home safety concerns	Yes / No
Mobility aids used	Cane / Walker / Wheelchair / None

IX. Summary & Care Plan

Area of Concern	Intervention Plan	Referral Needed? (Y/N)

Date of Next Review: ___________

Nurse Name:______________________

Signature: ______________________

Date:___________________

Time:_________________