UWO Comprehensive Geriatric Assessment Guide (CGAG)
Patient/Caregiver Feedback Questionnaire

Instructions
After your appointment, please score the trainee using this form.

1. GETTING STARTED The trainee …..	Yes	No	Don't remember
Ensured I could hear them, without shouting at me.			
Engaged **me** in conversation instead of talking to my family.			
What did the trainee do well? Any areas for improvement? e.g. They listened to me.			

2. GATHERING INFORMATION The trainee…..	Yes	No	Don't remember
Provided opportunity for me **and** my family to share our concerns.			
Asked about medical problems. (e.g. blood pressure, diabetes, stroke)			
Asked about psychiatric problems. (e.g. depression, anxiety)			
Give examples of things that stood out in your interview. e.g. The trainee spoke too quickly.			

3. MEDICATIONS: The trainee asked me about:	Yes	No	Don't remember
Names/Types of pills I am currently taking.			
Any difficulty managing pills. (e.g. remembering to take, use of pill box)			
Any side effects of taking your medications. (e.g. nausea, vomiting)			
Any immunizations I have had.			
My use of **alcohol**. (e.g. Do you drink? How much? How often?)			
My use of **drugs**. (e.g. Do you use drugs? How much? How often?)			
My use of **tobacco**. (e.g. Do you smoke? How much? How often?)			
Additional comments:			

4. SYSTEMS REVIEW: The trainee asked me about:	Yes	No	Don't remember
Bowel function. (e.g. constipation, diarrhea)			
Bladder function. (e.g. leakage, unable to hold it, unable to go)			
Memory/Thinking. (e.g. problems remembering things, word finding)			
Mood. (e.g. general feelings of sadness, hopelessness)			
Vision.			

Hearing.			
Sleep.			
Weight. (e.g. lost or gained any weight)			
Eating habits. (e.g. appetite, eating more or less than usual)			
Feedback to trainee: (e.g.: I was glad you asked about…., you could have asked me about…..)			

5. FUNCTION: **The trainee asked me about my ability to:**	Yes	No	Don't know
Prepare meals			
Shop for groceries.			
Manage household chores. (e.g. laundry, cleaning)			
Manage money. (e.g. paying bills)			
Drive or use public transportation.			
Bathe myself. (e.g. need any help getting into tub, washing yourself)			
Groom myself. (e.g. shaving, applying makeup)			
Dress myself. (e.g. problems tying shoes, doing up buttons)			
Feed myself.			
Use the telephone.			
Walk independently with or without a gait aid.			
Manage any bowel or bladder difficulty			
Additional comments:			

6. SOCIAL WELL BEING: **You asked about my:**	Yes	No	Don't remember
Family and marital status			
Living arrangements. (e.g. live alone, type of house, number of floors)			
Supports. (family, friends, caregivers)			
Level of education and career.			
Career/work history.			
Hobbies			
Financial situation. (e.g. sources of income, money worries, etc)			
Power-of-Attorney [POA]. (e.g. Do you have a POA for Health? Finance?)			
Personal Safety. (e.g. falls, fires, getting lost)			
Additional comments:			

7. COGNITIVE EVALUATION: **The trainee……**	Yes	No	Don't remember
Completed the MoCA test.			

Feedback to trainee:

My Date of Birth (Month/Year): ______________________ My Sex: Male _____ Female _____

How far I went in school: ___________________________

My relationship to person who came with me: ____