Registration No.:_____ Citizenship ID No.:_____

Name:_____ Age:_____ Gender: ☐ M ☐ F

Present address:

Permanent address: _____

Mobile:_____ Name of primary care giver:_____

Relationship: _____ Contact number: _____

Education: (Grade): ☐ Primary ☐ Secondary ☐ Tertiary ☐ Illiterate ☐ Non-formal

Others (specify): _____

Occupation:_____ Past occupation:_____

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Widowed

Living with (family/alone) if with family: number of family members_____

Current Address:_____

Symptoms (if yes tick boxes):

☐ Headache	☐ Diarrhea	☐ Constipation	☐ dental problem	☐ skin problem
☐ Dizziness	☐ Neck pain	☐ Urinary problem	☐ Breathlessness	☐ Cough
☐ Chest pain	☐ Palpitation	☐ Abdominal pain	☐ Shoulder pain	☐ Knee pain
☐ Backache	☐ Weight loss	☐ Nausea	☐ Vomiting	☐ H/O fall

Screening for intrinsic capacity:

☐ Memory decline ☐ Limited mobility ☐ Malnutrition ☐ Visual impairment Hearing loss

☐ Depressive symptom

Past History:_____

Present Medications:_____

H/O Allergy:_____

H/O Vaccination:_____

H/O Addiction:_____

Family History (Diabetes, Tuberculosis, Hypertension, Bronchial asthma, Cancer, etc.)

Physical Examination

General:

Blood pressure:_____ Pulse:_____ (Regular/irregular) BMI:_____(kg/m2)

RBS (Using glucometer):_____ Others (as appropriate):_____

Systemic:

Heart:

Lungs:

1. Disability

a. Are you able to walk on your own?

3 = able to do it independently
2 = need some occasional help (ex. handrail and walking stick)
1 = able to do only with someone's help
0 = not able to do at all

b. Are you able to walk up the staircase?

3 = able to do it independently
2 = need some occasional help (ex. handrail and walking stick)
1 = able to do only with someone's help
0 = not able to do at all

c. Are you able to feed yourself?

3 = able to do it independently
2 = need some occasional help
1 = able to do only with someone's help
0 = not able to do at all

d. Are you able to pass urine and move the bowel on your own?

3 = able to do it independently
2 = need some occasional help
1 = able to do only with someone's help
0 = not able to do at all

e. Are you able to bathe on your own?

3 = able to do it independently
2 = need some occasional help
1 = able to do only with someone's help
0 = not able to do at all

f. Are you able to change clothes on your own?

3 = able to do it independently
2 = need some occasional help
1 = able to do only with someone's help
0 = not able to do at all

g. Are you able to wash and comb your hair on your own?

3 = able to do it independently
2 = need some occasional help
1 = able to do only with someone's help
0 = not able to do at all

a+b+c+d+e+f+g =_____/21

☐ 21

☐ Less than 21 (need care in basic ADL)

2. Diabetes

Random Blood Sugar (RBS)_____mg/dL Anti-diabetic medicine ☐ Yes ☐ No

☐ RBS <200mg/dL and not taking anti-diabetic medicine (normal)

☐ RBS >200mg/dL or taking anti-diabetic medicine (need further examination)

3. Depression

a. Over the two weeks have you felt down, depressed, or hopeless? 1= yes 0= no

b. Over the past two weeks, have you felt little interest or pleasure in doing things? 1= yes 0= no

☐ a+b = 0

☐ a+b = 1 or more (risk for depression)

4. Dementia

Please listen carefully and remember 3 unrelated words. (e.g. banana, dog, coin)

(After 3 minutes)

Please repeat the three words given previously. _____ _____ _____ Score_____/3

☐ 2 or more

☐ Less than 2 (risk for dementia)

5. Oral and Dental health

☐ Teeth present ☐ Teeth absent

☐ Any oral ulcers/swelling

☐ Others (specify)…….

6. Isolation

How many members are you living together in your house including you?

Total_____ (spouse ,children ,grandchildren ,other relatives ,others)

Living alone ☐ yes ☐ no

FAMILY: Considering the people to whom you are related by birth, marriage, adoption, etc.

a. How many relatives do you see or hear from at least once a month?

0 = none, 1 = one, 2 = two, 3 = three or four, 4 = five thru eight, 5 = nine or more

b. How many relatives do you feel at ease with that you can talk about private matters?

0 = none, 1 = one, 2 = two, 3 = three or four, 4 = five thru eight, 5 = nine or more

c. How many relatives do you feel close to such that you could call on them for help?

0 = none, 1 = one, 2 = two, 3 = three or four, 4 =five thru eight, 5 = nine or more

FRIENDSHIPS: Considering all of your friends including those who live in your neighborhood

d. How many of your friends do you see or hear from at least once a month?
0 = none, 1 = one, 2 = two, 3 = three or four, 4 =five thru eight, 5 = nine or more

e. How many friends do you feel at ease with that you can talk about private matters?
0 = none, 1 = one, 2 = two, 3 = three or four, 4 =five thru eight, 5 = nine or more

f. How many friends do you feel close to such that you could call on them for help?
0 = none, 1 = one, 2 = two, 3 = three or four, 4 =five thru eight, 5 = nine or more

a+b+c+d+e+f=_____/30

☐ 12 or more

☐ Less than 12 (risk for isolation)

7. Hypertension

BP (sitting) 1st_____/_____mmHg HR_____/min

2nd_____/_____mmHg HR_____/min

Mean BP (sitting)_____/_____mmHg HR_____/min

Anti-hypertensive medicine ☐ Yes ☐ No

☐ mSBP<140mmHg/mDBP<90mmHg and not taking anti-hypertensive medicine (treatment plan)

☐ mSBP>140mmHg/mDBP>90mmHg or taking anti-hypertensive medicine
(Uncontrolled Hypertension: book for further investigation)

8. Addiction

Are you smoker? (including chewing tobacco) ☐ current smoker ☐ ex-smoker ☐ non-smoker

Are you doma consumer? ☐ current consumer ☐ ex-consumer ☐ non-consumer

Do you drink alcohol? ☐ yes daily ☐ yes occasionally ☐ no

Do you take more than two cups of beer (500ml), more than half cup of ara (100ml), or equivalent amount of alcohol, every day? ☐ Yes ☐ No

a. Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No

b. Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No

c. Have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No

d. Have you ever had a drink first thing in the morning (as an eye opener) to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

a+b+c+d= (CAGE questions)

☐ Less than 2

☐ 2 or more (risk for alcoholism)

9. Visual Health

☐ Difficulty in seeing

☐ Uncorrected distance visual acuity

☐ Others (specify)……

10. Hearing problems

Right Hearing: ☐ Normal ☐ mild ☐ moderate ☐ severe ☐ profound

Left Hearing: ☐ Normal ☐ mild ☐ moderate ☐ severe ☐ profound

11. Fall risk

Did you fall down within a month? ☐ Yes ☐ No

Poly-pharmacy (more than 3 drugs, any type) ☐ Yes ☐ No

Psychotropic drugs ☐ Yes ☐ No

Timed Up & Go test_____sec ≥12sec (distance 10ft) ☐ Yes ☐ No

30 sec Chair test _____ <10times ☐ Yes ☐ No

Four stage balance test: ☐ Yes ☐ No

☐ **None of the above test applies to the patient**

☐ **At least 1of the above test applies to the patient**

12. Urinary Incontinence

Have you experienced dripping of urine? ☐ Yes ☐ No

13. Nutritional problems:

Height:_____cm Weight:_____kg BMI_____kg/m2

☐ BMI <18.5kg/m2 (underweight)

☐ 18.5kg/m2 < BMI <25kg/m2 (normal range)

☐ 25kg/m2 < BMI <30kg/m2 (overweight)

☐ BMI >30kg/m2 (obese)

How many full meals do you eat daily?

☐ No meal ☐ One meal ☐ 2 meals ☐ 3 meals or more

At least 1serving of dairy products (milk, cheese, yoghurt) per day.

☐ Yes ☐ Depending on the season ☐ No

2 or more servings of legumes or eggs per week.

☐ Yes ☐ Depending on the season ☐ No

Meat, fish or poultry every day

☐ Yes ☐ Depending on the season ☐ No

Consumes 2 or more servings of fruit or vegetables per day?

☐ Yes ☐ Depending on the season ☐ No

14. Social care and support

What do you think of your current health status?

☐ Good ☐ Neither good nor bad ☐ Bad

What do you think of your relationship with your family

☐ Good ☐ Neither good nor bad ☐ Bad

What do you think of your relationship with your friends?

☐ **Good** ☐ **Neither good nor bad** ☐ **Bad**

What do you think of your current financial status?

☐ **Satisfactory** ☐ **Not satisfactory**

What makes you unhappy?

What makes you happy?

Provisional Diagnosis:_____

Advice:

Personalized care plan (after social care and support assessment):

Name of Health Facility:

Dzongkhag:

Signature:

Reporting Officer:

Designation:

Date: (dd) / (mm) / (yyyy)

15. Could you please give us advice for improvements of the program?