Home Visit Checklist

Patient's name: ____

Address: Telephone number: ____________________

Family members:

____

Addresses and telephone numbers of family members:

____

____

____

***I*mpairments/*I*mmobility**

Activities of daily living (ADL)	Yes	No	Instrumental ADLs	Yes	No
Balance and gait problems	Yes	No	Sensory impairments	Yes	No

***N*utrition**

Meals ____

Variety and quality of foods	Pantry _____	Refrigerator _____	Freezer _____
Nutritional status	Obesity _____	Malnutrition _____	Other _____
Alcohol presence/use	Yes No		

***H*ome environment**

Neighborhood

____

Exterior of home

____

Interior of home Crowding _____ Housekeeping _____ Homeyness _____ Privacy _____

Pets _____ Books _____ Television _____ Memorabilia _____

***O*ther people**

Social supports	Yes	No
Living will	Yes	No
Power of attorney	Yes	No

Financial resources
____

Patient attitudes ____

***M*edications**

Prescription drugs	Yes	No
Nonprescription drugs	Yes	No
Dietary supplements	Yes	No
Medicines organized	Yes	No
Medication compliance	Yes	No

***E*xamination**

Weight _____ Height _____ Blood pressure _____ Glucose _____

Urinalysis _____ Other _____ Mini-Mental State _____ General physical condition _____

***S*afety, *S*piritual health and *S*ervices**

Bathroom _____ Kitchen _____ Carpets _____ Lighting _____ Electrical cords _____

Stairs _____ Tables, chairs and other furniture _____

Fire and smoke detectors _____ Fire extinguishers _____ Emergency plans _____ Evacuation route ____

Gas or electric range _____ Hot water heater _____

Heating and air-conditioning _____ Water source _____

Spiritual health
____

Home health services