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**Patient Falls Questionnaire**

To help us make your appointment more efficient and appropriate to you, please take some time to complete the following questions **prior to** your appointment.

**Please describe the falls that you have had over the past year.**

***Falls include a slip or trip in which you lost your balance and landed on the floor or ground or lower level.***

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| **How did you fall and when? (Give dates if you can remember)** |
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| **Have you been diagnosed with any of the following conditions: (Tick all that apply)** |
| **Asthma** |  | **Osteoarthritis** |  | **Neurological condition** |  |
| **Bronchitis** |  | **Rheumatoid arthritis** |  | **Stroke / mini Stroke** |  |
| **C.O.P.D.** |  | **Joint replacement** |  | **Memory problems** |  |
| **Low BP** |  | **Major surgery** |  | **Cancer** |  |
| **High BP** |  | **Osteoporosis/thin bones** |  | **Thyroid problem** |  |
| **Heart condition** |  | **Fracture/broken bones** |  | **TB** |  |
| **Ear problems** |  | **Prescribed steroids** |  |  |  |

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| **Please list the medication that you currently take, including dose.**Bring a copy of your prescription with you to your appointment. |
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| **Have you EVER had: dizziness, light-headedness, room spinning or related symptoms? Yes/No** |

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| **Name:** |  | **Date of birth:** |  |
| **Signature:** |  | **Today’s date:** |  |