

**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.***

How you did fall and dates:

**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** |  |

**Please list the medication that you currently take, including dose.**

Bring a copy of your prescription with you to your appointment.

**Have you EVER had: Dizziness, Light-headedness, room spinning or related symptoms? Yes/No**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**