Family Practice of Suntree and Viera, P.A.

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NAME:_____ DOB: _____ DATE: _____

Fall Risk and Balance Assessment

0518F. 1100F, 1101F, 3288F

Please read and circle the answer for each question

1.	Have you fallen in the past year?	No	Yes
2.	Do you feel weaker than you used to or less strength in your arms or legs?	No	Yes
3.	Have you stopped doing daily activities because you are afraid of falling?	No	Yes
4.	Do you feel unsteady, stagger or shuffle when you walk?	No	Yes
5.	Do you get dizzy, faint or have seizures?	No	Yes
6.	Have you had a recent loss or decrease in your vision?	No	Yes
7.	Do you have numbness or tingling in your legs or feet?	No	Yes
8.	Have you experienced hearing loss?	No	Yes
9.	Do you experience any incontinence?	No	Yes

Screening questions

	Do you have any occasional memory loss or forgetfulness?	No	Yes
	Have you had a colon cancer screening?	No	Yes-when:_____
	Have you had your yearly glaucoma screening?	No	Yes-when:_____
	Have you had an EKG or Chest x-ray in the last year?	No	Yes-when:_____
Diabetics:	Have you had your toenails trimmed?	No	Yes-when:_____
Women:	Have you had your well woman pap smear?	No	Yes-when:_____
Men:	Have you had your prostate checked?	No	Yes-when:_____