Falls Care Program Pre-Visit Questionnaire

To prepare for your visit, please update the following information to help us identify any current risks for falls-related injuries.

Name: _____ **Date:** _____/_____/_____
Month Day Year

Are you afraid of falling? ☐ Yes ☐ No

Have you had a fall since your last Fall Care visit? ☐ Yes ☐ No

If yes, how many times have you fallen since your last visit? _____

Please explain:_____

Have you had any new vision problems since your last Fall Care visit? ☐ Yes ☐ No

Have you been examined by an eye doctor in the past year? ☐ Yes ☐ No

Do you wear multifocal glasses? ☐ Yes ☐ No

Do you have any foot problems? ☐ Yes ☐ No

Have there been any changes in the medicines you take since your last visit? ☐ Yes ☐ No *If yes,* which one(s)? _____

Do you think any of the medicines you are taking are causing the following symptoms? ☐ Yes ☐ No *If yes,* please indicate:

Symptom	Name of Medicine(s)
☐ Unsteadiness or dizziness	_____
☐ Frequent trips to the bathroom	_____
☐ Drowsy, Foggy, or sleepy	_____

Do you sometimes take medications differently than prescribed (e.g, skip or reduce doses?) ☐ Yes ☐ No *If yes,* which one(s)? _____

Do you ever forget to take any of your medications? ☐ Yes ☐ No
If yes, which one(s)? _____

When you feel better, do you sometimes stop taking any of your medications? ☐ Yes ☐ No *If yes,* which one(s)? _____

Sometimes if you feel worse when you take one of your medications, do you stop taking it? ☐ Yes ☐ No *If yes,* which one(s)? _____

Do you ever stop taking your medications because they are too expensive? ☐ Yes ☐ No *If yes,* which one(s)? _____

Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

☐ Daily ☐ A few days a week (specify number of days: _____)

☐ Less than once a week ☐ Never

How much do you drink at a time? (One drink = 12 oz of beer or 8-9 oz of malt liquor or 5 oz of table wine or 1.5 oz of hard alcohol)

☐ 1 drink ☐ 2 drinks ☐ 3 drinks ☐ 4 drinks ☐ 5+ (how many____)

Has anyone ever been concerned about your drinking? ☐ Yes ☐ No

Do you have pain? ☐ Yes ☐ No *If yes,* where is your pain located? _____

Does your pain limit your ability to participate in daily activities or do the things that are important to you? ☐ Yes ☐ No

Are you currently participating in any regular activity to improve or maintain your physical activity? ☐ Yes ☐ No

If yes, please specify: _____

In order to best serve you, please list any specific health concerns that you would like the **falls care manager** to know about before your visit.

Include any information NOT already reported in this form:

_____

_____

Thank you for taking the time to complete this form.