Falls Care Program Pre-Visit Questionnaire

To help us get to know you better, please complete this form before your visit and bring it with you to the visit. It will help us to work with you to reduce your risk of falling.
We look forward to working with you.

I. PERSONAL INFORMATION (*Please print all responses throughout the form)*

Name of Patient: _____
Last First Middle

Email address: _____

WHO COMPLETED THIS FORM:

☐ Self (***skip to section II***) ☐ Other (*provide information below)*

Relationship to the patient: _____

Name: _____
Last First Middle

Phone: (_____)_____ (____)_____
Home Mobile

Email address: _____

What are the best times to contact the person completing the form (M-F, 8am-5pm)? _____

II. PHYSICIAN INFORMATION

Name of patient's PRIMARY CARE DOCTOR or PROVIDER:

_____
Last Name First Name

Phone: (____)_____(____)_____
Office Fax

Do you have any other doctors/providers (e.g., cardiologist, neurologist, rheumatologist, or orthopedist, ophthalmologist, podiatrist)? ☐ Yes ☐ No

Other Provider's Name	Specialty	Phone

III. INFORMATION ABOUT FALLING

Are you afraid of falling? ☐ Yes ☐ No

Have you had a fall in the past year? ☐ Yes ☐ No

If no, skip to **Do you use a walking aid.**

If yes, how many times have you fallen during the past year _____

When was your most recent fall? _____

Below, please indicate the circumstances and consequences of your most recent fall.

Where were you when you fell?

_____

What were you doing when you fell?

_____

Did you trip over something? ☐ Yes ☐ No

Did you report your fall to your healthcare provider? ☐ Yes ☐ No

Did you have lightheadedness or heart fluttering prior to the fall? ☐ Yes ☐ No

Did you consume alcohol within two hours of your fall? ☐ Yes ☐ No

Did you lose consciousness when you fell? ☐ Yes ☐ No

Did you lose control of your urine when you fell? ☐ Yes ☐ No

Were you able to get up by yourself? ☐ Yes ☐ No

Were you injured when you fell? ☐ Yes ☐ No

If yes, what was the injury?

_____

Do you use a walking aid? ☐ Yes ☐ No

If yes, which one(s)? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Motorized scooter

When do you use the walking aid? ☐ All the time ☐ Only _____

Have you received physical (PT) or occupational therapy (OT) in the past year?

☐ Yes ☐ No

Month/year Completed | Month/year Completed

If yes, which ones, where, when?

☐ PT in office ____/_____ ☐ PT at home____/_____

☐ OT in office ____/_____ ☐ OT at home ____/_____

Have you been examined by an eye doctor in the past year?

☐ Yes – Date: _____ ☐ No

IV. YOUR HEALTH

Your medications:
Please list all medications and supplements, including those prescribed to you and those you purchase without a prescription (e.g., Tylenol, allergy relief medications, sleep aids), and supplements or natural products (e.g., vitamins) that you are currently taking regularly or as needed.

Prescribed medication name	Dose	Number of pills and times per day	What is this medication for?	How long have you been taking this medication?
Example: Lasix	*20mg*	*1 pill twice a day*	*Heart failure*	*2 years*
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Do you think that any of the medications you are taking make you unsteady, dizzy or lightheaded?

☐ Yes ☐ No If yes, which one(s)? _____

Do you think that any of the medications you are taking make you drowsy, foggy, or too sleepy?

☐ Yes ☐ No If yes, which one(s)? _____

Do you think that any of the medications you are taking make you need to go to the toilet frequently?

☐ Yes ☐ No If yes, which one(s)? _____

Do you sometimes take medications differently than they are prescribed (such as skipping or reducing 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)? _____

If you feel worse when you take one of your medications, do you sometimes 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)? _____

Which medical conditions and symptoms do you have now or have had in the past? (Please check all that apply):

EYE & EAR

☐ Distant vision loss ☐ Macular degeneration ☐ Multifocal glasses

☐ Near vision loss ☐ Glaucoma

☐ Cataracts ☐ Diabetic vision loss

HEART

☐ Orthostatic Hypotension
☐High blood pressure
☐ Aortic stenosis
☐ Heart valve problem
☐Atrial fibrillation
☐ Shortness of breath with walking
☐ Irregular heartbeats (Arrhythmia)

BONES, JOINTS, AND MUSCLES

☐ Osteoporosis
☐ Foot problems
☐ Foot pain
☐ Leg pain with walking
☐ Rheumatoid arthritis
☐ Leg pain at rest
☐ Fracture occurring from fall at standing height or less

☐ Fractured Bone: ☐ hip ☐ spine ☐ wrist ☐ other (specify): _____

☐ Arthritis *(check affected area on body):* ☐ hip ☐ knee ☐ neck ☐ shoulder ☐ back ☐ hands

☐ Joint replacement (check affected area on body): ☐ hip ☐ knee

Have either of your parents fractured a hip? ☐ Yes ☐ No ☐ Don't Know

NERVOUS SYSTEM

☐ Balance problems
☐ Dizziness or unsteadiness
☐ Lightheadedness
☐ Vertigo or spinning sensation
☐ Parkinson's disease
☐ Neuropathy/nerve damage
☐ Numbness or loss of feeling

KIDNEY & URINARY TRACT

☐ Loss of urine or getting wet (incontinence)
If yes,
☐ Sudden urge to void
☐ Getting to the toilet on time
☐ Urination at night
If yes, how many times a night:_____
☐ Kidney disease

MENTAL HEALTH

☐ Alzheimer's disease or other Dementia

☐ Problems with memory

☐ Anxiety

☐ Depression

☐ Insomnia or problems with sleep

☐ Daytime sleepiness

☐ Other _____

PAIN

Do you have pain?

Where is your pain located?

Does your pain limit your ability to participate in daily activities or do things that are important to you?

ENDOCRINE (Glands and hormones)

☐ Diabetes ☐ Early Menopause (before age 45)

Have you ever taken any steroid medications (such as Prednisone)?

☐ Yes ☐ No If yes, which one(s)? _____

V. YOUR LIFE

Who do you live with? (Please check all that apply):

☐ Alone ☐ Spouse or Partner ☐ Child

☐ Other family member(s): _____

☐ Other, not family member(s): _____

Who would you call if you were sick and needed help? (check all that apply)

☐ Spouse/Partner ☐ Neighbor ☐ Daughter

☐ Friend ☐ Son ☐ Other (specify): _____

Please list name(s) and phone number(s) of person(s) checked off above:

Name:_____ **Phone: (_____)**_____

Name: _____ **Phone: (_____)**_____

Do we have your permission to speak to the person(s) listed above on your behalf?

☐ Yes ☐ No

List your principal occupation and other significant past occupations (indicate current status)

1. _____ ☐ Working full-time ☐ Working part-time ☐ Retired
2. _____ ☐ Working full-time ☐ Working part-time ☐ Retired

Do you employ someone to provide health-related care or help you in your home?

☐ Yes ☐ No

If yes, how many hours per day and days per week, is the paid helper available to you?

_____ Hours _____ Days per week *(e.g. 3 hours, 5 days per week)*

_____ Hours _____ Days per week *(complete if hours vary on different days)*

Does this adequately meet your needs? ☐ Yes ☐ No

Do you get help from family members or friends in your home? ☐ Yes ☐ No

If yes, how many hours per day and days per week, is the helper available to you?

_____ Hours,_____ Days per week *(e.g. 3 hours, 5 days per week)*

Does this adequately meet your needs? ☐ Yes ☐ No

Please name family/friend who provides help: _____

If this family/friend were to get sick or hospitalized, who would provide help?

_____

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

Have you ever smoked cigarettes? ☐ Yes ☐ No

If yes, do you currently smoke cigarettes? ☐ Yes ☐ No

☐ No… If no, when did you quit? Year _____

VI. YOUR HOME

Which of the following best describes your residence?

☐ Single-family house ☐ Condo or retirement community

☐ Board & Care/Assisted Living ☐ Apartment

☐ Mobile Home ☐ Other (specify): _____

How long have you lived at your current residence? _____

Number of levels? _____ Number of stairs? _____

VII. YOUR ACTIVITIES

Do you currently participate in any regular activity to improve or maintain your physical fitness? *(either on your own or in a formal class)* ☐ Yes ☐ No

***If yes*, what do you do?**

_____

How many days per week do you exercise (check box):

Amount of time per day _____ (minutes/hours)

Would you like to exercise more than you do right now? ☐ Yes ☐ No

HELP WITH DAILY ACTIVITIES (Please check the most appropriate box for each task)

	No Help Needed	Help Needed	Who Helps?
Eating	☐	☐	_____
Getting from bed to chair	☐	☐	_____
Getting to the toilet	☐	☐	_____
Getting dressed	☐	☐	_____
Bathing or showering	☐	☐	_____
Walking across the room (*includes using a cane or walker)*	☐	☐	_____
Using the telephone	☐	☐	_____
Taking your medicines	☐	☐	_____
Preparing meals	☐	☐	_____
Managing money *(e.g., keeping track of expenses or paying bills)*	☐	☐	_____
Moderately strenuous housework *(e.g., doing laundry)*	☐	☐	_____
Shopping for personal items *(e.g., toiletries or medicine)*	☐	☐	_____
Shopping for groceries	☐	☐	_____
Driving	☐	☐	_____
Climbing a flight of stairs	☐	☐	_____
Walking ¼ mile (3-4 blocks)	☐	☐	_____
Getting to places beyond walking Distance *(e.g. by bus, taxi or car)*	☐	☐	_____

VIII. COMMUNITY SERVICES

Please check the box for each community-based service you are currently receiving and any services you would be interested in receiving in the future.

	Currently receiving	**Interested in receiving**
Walking program	☐	☐
Falls prevention program	☐	☐
Home Health Care	☐	☐
Home safety modification *(e.g., grab bars, commodes)*	☐	☐
Medication management program	☐	☐
Veteran's services	☐	☐
Exercise program	☐	☐

If receiving or interested in an exercise program, what type?

_____

Do you have transportation available to attend treatment programs or activity programs that are offered outside of your home at least 1 day per week? ☐ Yes ☐ No

IX. OTHER HEALTH CONCERNS

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:

Please review the Home Safety Checklist enclosed in your packet and bring it to your appointment with you.

Thank you for taking the time to complete this form.