

VISIT FORM: FALLS/MOBILITY PROBLEMS

Part I: To Be Filled out by the Patient OR Caregiver



Name: _____

Reason for Visit:

- Fall since last visit (or in last year, if new patient)
- Fear of falling, balance/trouble walking
- Assistive device used for mobility

Other: _____

1. If you fell, approximate date of last fall: _____

2. How many times have you fallen in the last year? _____

2. a. Please describe any injuries from these falls: _____

3. Circumstances of fall:

- Loss of Consciousness Yes No
- Tripped/stumbled over something Yes No
- Lightheadedness/palpitations Yes No
- Unable to get up within 5 minutes Yes No
- Needed Assistance to get up Yes No

Narrative explanation of what you were doing when you fell: _____

4. Total Number of Prescribed Medications you take: _____

List all prescription medication you are on: _____

5. Two or more drinks of alcohol each day Yes No

6. Do you ever have urinary leakage? Yes No

7. Do you ever feel dizzy?

- Do you ever feel like you or the room is spinning? Yes No
- Do you get dizzy when you feel anxious? Yes No
- Do you ever get dizzy when you lie down and look up? Yes No
- Do you get dizzy when you stand up? Yes No
- Do you get dizzy when you have a headache? Yes No

8. Do you have a device to help you get around?

- Cane Yes No
 - Walker Yes No
 - Wheelchair Yes No
 - Leg/Foot Brace Yes No
 - Other, specify: _____
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9. Do you have or had any of the following conditions?

- Parkinson's Stroke Heart Problems Neuropathy Dementia
- Multiple Sclerosis Amputation.

Please list other medical problems:

10. Vision:

- Have you noticed a recent vision change? Yes No
- Have you had an exam in past year? Yes No
- Do you wear bifocals or trifocals? Yes No
- Do you ever trip when stepping up a curb or stairs? Yes No

11. Social Situation

I live in: Apartment Family House Patio Home Assisted Living Facility
 Residential Home Senior Housing Nursing Home

- I live alone Yes No
- I have to use stairs where I live..... Yes No
- I am able to leave my home..... Yes No
- I have a care assistant at home Yes No
- I have grab bars in my bathroom..... Yes No
- I have throw rugs in my home..... Yes No

12. How many minutes of exercise (such as walking, golfing, aerobics) do you engage in each week?
