Q2/01/2023 07:59 T-08:00 TO: +17323419968 FROM: 8669181903

## Fall Prevention Balance and Dizziness Survey

Patient Name:	Age:	Da	te:		
To help determine if you may be headed for a fall or have a If you answer yes to one or more of the questions, you could problem is to share with the doctor any fears or concerns you that he or she may help determine the cause of your sympton	be at risk. The	haat war (	- d	: : <i>C</i>	1
Please read each question and check the box that mo answer.	st describes y	our	1	Some-	No or Never
1. Have you fallen more than once in the past year wit cause?	hout an obvio	us			
2. Do you ever fall or feel like you are about to fall for	no apparent r	eason?			
3. Do you fear falling or are you worried about losing y					
4. Have you experienced dizziness, vertigo, or serious i six months?		he past			
5. Do you feel unsteady when you are walking or climb	ing stairs?				
6. Do you feel dizzy while sitting down or rising from a position?	seated or lyin	g			
7. Does walking down the aisle of a supermarket or sto traffic make you dizzy?	pping next to	moving			
8. Does moving your head quickly make you dizzy or ca nauseous?	use you to fee				
9. Are you dizzy or unsteady when you first get up in th	e morning?				
10. Have you continued to experience dizziness after an	injury or acci	dent?			
L1. Do you use or have you ever been advised to use a vother form of assistance for your mobility?					
l2. Have you had a recent loss of, or decrease in, your v	ision or heari	ng?			
13. Does dizziness or imbalance interfere with your job esponsibilities?	or your house	hold			
.4. Has your balance problem caused problems in your	ocial life?				
.5. Do you ever lose your balance or feel dizzy or unstea	dy?				
.6. Do you steady yourself by holding onto furniture wh	en walking at	home?			
ease fill out the top with your name and date, sign the survey at the bottor			ician durin	g your vis	it.
Patient Signature	***************************************	Phone		<del></del>	