Stay Safe at Home

Pacific County Fire Dist.1 Prevention Program

Falls Risk Questionnaire

Name: _____ Date of Visit: _____

Address:_____ Age:____

BP: _____ Heart Rate: _____

Falls Risk Factor	Factors Present?
Falls History	
How many falls in the past year? Injuries?	
Where/How? ☐ GLF – Slip, Trip, Stumble ☐ Stairs/Steps ☐ In/Out of Bed	☐ Bathroom ☐ Wheelchair ☐ In/Out of Chair ☐ Outside?
Medical Alert Button?	☐ Yes ☐ No If yes, what system? _____
Vision	
Acuity <20/40 OR no eye exam in >1 year	☐ Yes ☐ No
Contacts/Glasses?	☐ Yes ☐ No
Cataracts? If yes, surgery to correct?	☐ Yes ☐ No ☐ Yes ☐ No
Medical Conditions	
Problems with heart rhythm/rate-fast/slow?	☐ Yes ☐ No
Health Conditions - ☐ Stroke ☐ Asthma	☐ COPD (Emphysema) ☐ Diabetes – Type I or II
Do you have a pacemaker or defibrillator?	☐ Yes ☐ No
Incontinence issues?	☐ Yes ☐ No
Foot problems? ☐ Yes ☐ No	☐ Diabetes/Neuropathy ☐ Edema
Arthritis/rheumatoid?	☐ Yes ☐ No
Artificial joints – hips/knees (both?)	☐ Yes ☐ No
Other medical conditions (Specify)	☐ Yes ☐ No _____

Medications	
Able to self-manage medications?	☐ Yes ☐ No
Safe storage of medications? ☐ Yes ☐ No	File of Life ☐ Yes ☐ No
Any psychoactive meds, meds w/ anticholinergic side effects, and/or sedating OTCs? (e.g., Benadryl, Tylenol PM)	*Reminder to get Medication List
Postural Hypotension	
Do you get lightheaded or dizzy from lying to standing?	☐ Yes ☐ No
Have you ever stood/sat up, passed out and woken up on the floor?	☐ Yes ☐ No
Gait, Strength & Balance	
30-Second Chair Stand Test Below average score	☐ Pass ☐ Fail
Areas of Concern with ADL	
☐ Household Chores ☐ In/out of Vehicle ☐ Homebound ☐ Other ☐ In/Out of Chair ☐ Meal Preparation	☐ Dressing ☐ Bathing ☐ Toileting ☐ In/Out of Bed
Footwear	
What type of shoes do you normally wear?	☐ Athletic ☐ Walking ☐ Sandals ☐ Slippers
Adequate footwear? Non-slip soles, firmly fastened (Velcro/laces), low heel	☐ Yes ☐ No
Areas of Concern when walking?	
Steady self by holding furniture at home?	☐ Yes ☐ No
Advised to use assistive device? ☐Yes ☐No	☐ Cane ☐ Walker ☐ Crutches
Trouble stepping on/off curb? ☐ Yes ☐ No	Walk/exercise regularly? ☐ Yes ☐ No
Concerns when walking? ☐ Pets ☐ In the house ☐ Up/down stairs	☐ In/Out of the house ☐ In the yard ☐ At night ☐ In the community

Notes:

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