

# MY FALL RISK ASSESSMENT

You may not know it, but you could be at risk of falling. Early detection is important to avoid injury. Knowing ahead of time is essential to maintaining mobility and independence. People who are concerned with staying active and healthy are taking steps to ensure they are protected against the risks of falling.

If you are over the age of 50 please take a couple of minutes to complete this questionnaire. The results will serve as a guide to inform you as to how safe you are from falling and the areas in which you might improve. If you have osteoporosis, your risk of injury may be higher.

Then take a moment to discuss it with your health professional. Doctors, Nurses, Physiotherapists, Occupational Therapists and Pharmacists can provide advice and assistance to get you the right services.

	YES	NO
<b>My history of falling:</b>		
I have had at least one fall in the last 6 months	<input type="checkbox"/>	<input type="checkbox"/>
<b>About my medications:</b>		
I regularly take sleeping tablets or tranquillizers or antidepressants	<input type="checkbox"/>	<input type="checkbox"/>
I take 4 or more different types of medications each day	<input type="checkbox"/>	<input type="checkbox"/>
<b>About my levels of exercise:</b>		
I do less than 30 minutes of physical activity in a day on most days of the week (such as housework, gardening or bowls)	<input type="checkbox"/>	<input type="checkbox"/>
<b>About my balance and walking:</b>		
I have difficulty getting up from my chair	<input type="checkbox"/>	<input type="checkbox"/>
I feel unsteady when walking	<input type="checkbox"/>	<input type="checkbox"/>
My foot/feet are painful or swollen	<input type="checkbox"/>	<input type="checkbox"/>
<b>About my health conditions:</b>		
I have, or previously had the following:		
Problems with my heart, blood pressure, or circulation	<input type="checkbox"/>	<input type="checkbox"/>
A stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or light headed	<input type="checkbox"/>	<input type="checkbox"/>
A need to rush to the toilet	<input type="checkbox"/>	<input type="checkbox"/>
A recent major change in my health	<input type="checkbox"/>	<input type="checkbox"/>
<b>About my eyesight:</b>		
I have poor eyesight	<input type="checkbox"/>	<input type="checkbox"/>
It has been more than 2 years since my eyes were last tested	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered YES for more than one of these questions, please discuss this questionnaire during your next appointment with your Health Professional