EvergreenHealth
GERIATRIC CARE

Geriatric Care Fall Assessment Questionnaire

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How many times have you fallen in the past 12 months?	1	>2
Do you wear shoes while in your home?	❒Yes	❒No
Have you had any Emergency room or hospital visits as a result of a fall?	❒Yes	❒No
Have you had any injuries from a fall?	❒Yes	❒No
What type of injury?	_____	
Were you dizzy or lightheaded at the time of the fall?	❒Yes	❒No
Do you feel unsteady when you walk?	❒Yes	❒No

Do you have any of the following medical problems?

Arthritis	❒Yes	❒No
Osteoporosis	❒Yes	❒No
Impaired vision	❒Yes	❒No
Muscle weakness	❒Yes	❒No
Memory issues	❒Yes	❒No
Urine incontinence	❒Yes	❒No
Heart disease	❒Yes	❒No
Irregular heart rhythm	❒Yes	❒No
Strokes	❒Yes	❒No
Diabetes	❒Yes	❒No
Seizures	❒Yes	❒No
Parkinson's disease	❒Yes	❒No
Low vitamin D levels	❒Yes	❒No