MT. VERNON
INTERNAL
MEDICINE

Patient name: _____

Date: _____

FALL PREVENTION SURVEY

- Do you have any concerns about falling?

  _____

  _____

- Have you ever been assessed for your risk of falling in the past?

  _____

  _____

- Have you made any changes in your home to help reduce your risk of falling?

  _____

  _____

- Has your doctor or pharmacist talked to you about medications you take that could impact your balance?

  _____

  _____

- Have you had a fall with an injury in the last year? If yes did you follow up with a health care provider?

  _____

  _____