**Fall Risk Factor Identified Present? Notes**

|  |  |  |  |
| --- | --- | --- | --- |
| **FALLS HISTORY** |  |  |  |
| Any falls in the past year? | Yes | No |  |
| Worries about falling or feels unsteady when standing or walking? | Yes | No |  |
| **MEDICAL CONDITIONS** |  |  |  |
| Problems with heart rate and/or arrhythmia | Yes | No |  |
| Cognitive Impairment | Yes | No |  |
| Incontinence | Yes | No |  |
| Depression | Yes | No |  |
| Foot Problems | Yes | No |  |
| Other medical problems | Yes | No |  |
| **MEDICATIONS (PRESCRIPTIONS, OTC’S, SUPPLEMENTS)** |  |  |  |
| Psychoactive medications | Yes | No |  |
| Opioids | Yes | No |  |
| Medications that can cause sedation or confusion | Yes | No |  |
| Medications that can cause hypotension | Yes | No |  |
| **GAIT, STRENCTH & BALANCE** |  |  |  |
| Timed up and GO (TUG) ≥ 12 seconds | Yes | No |  |
| 30 Second Chair Stand Test: Below average based on age and gender | Yes | No |  |
| 4-Stage Balance Test: Fall tandem stance ≤ 10 seconds | Yes | No |  |
| **VISION** |  |  |  |
| Acuity < 20/40 OR no eye exam in > 1 year | Yes | No |  |
| **BLOOD PRESSURE** |  |  |  |
| Abnormal Blood Pressure | Yes | No |  |
| Lightheadedness or dizziness from a lying to standing position | Yes | No |  |

\*\*Table Based from CDC STEADI Fall Risk Factor Checklist. Please take this form to your Primary Care Physician.