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Patient's Name:

Date of Birth:

Date:

Doctor, Am I at Risk for Falls?

- About 1.5 million bone fractures occur in the United States each year.
- Hip fractures are increasing out of proportion to the aging population.
- Half of those who have fallen will fall repeatedly.
- Of those who have had a bone fracture, 40% cannot walk independently and 20% have a permanent disability.
- There is a higher mortality rate for men who have bone fractures than for women.

Talk to your doctor and discuss your risk of falls. Together, you and your doctor can help prevent injuries from falls.

Check "Y" (for Yes) or "N" (for No) next to each question below. Give the completed form to your doctor at your next visit.

In the past 12 months, I . . .

- | | |
|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Fell two or more times. | <input type="checkbox"/> Y <input type="checkbox"/> N Took medication that caused me to feel dizzy or light headed. |
| <input type="checkbox"/> Y <input type="checkbox"/> N Was injured by a fall that limited my regular activities for at least one day. | <input type="checkbox"/> Y <input type="checkbox"/> N Took 9 or more different medications |
| <input type="checkbox"/> Y <input type="checkbox"/> N Saw a doctor because I had a fall. | <input type="checkbox"/> Y <input type="checkbox"/> N Stopped some of my regular activities. |
| <input type="checkbox"/> Y <input type="checkbox"/> N Found it to be hard to climb stairs or walk a short distance. | <input type="checkbox"/> Y <input type="checkbox"/> N Have been taking a calcium supplement regularly. If "Yes," how much per day: |
| <input type="checkbox"/> Y <input type="checkbox"/> N Had trouble getting up from a soft chair. | <input type="checkbox"/> Y <input type="checkbox"/> N Have had my vitamin D level in my blood checked. |
| <input type="checkbox"/> Y <input type="checkbox"/> N Have been unable to stand on one foot for 12 seconds without losing my balance. | <input type="checkbox"/> Y <input type="checkbox"/> N Danced, exercised, or practiced Tai Chi at least 3 times a week. |
| <input type="checkbox"/> Y <input type="checkbox"/> N Trouble with my eyesight. | <input type="checkbox"/> Y <input type="checkbox"/> N Had my home checked for any dangers and modified as needed. |
| <input type="checkbox"/> Y <input type="checkbox"/> N Felt dizzy or light headed after a big meal. | |