It's falls month and we want to keep you safe!

You have been given this form to complete as the practice are undertaking a falls safety month. Please complete the below while you are waiting and discuss your answers with your GP.

(Islove GP Fall risk assessment tool – **Patient Version)**

Fall History		**Yes**	**No**
1	Have you had any falls in the past year?		
2.	Are you worried about falling?		
Your Details			
First Name:			
Surname:			
Date of birth:			
3	Do you use a walking aide or been advised to use one?		
4	Do you feel unsteady when walking or hold onto furniture when walking at home?		
5	Do you feel weak or have issues with balance or mobility? (You may push up with your hands from a chair or have difficulty stepping off from a curb)		
6	Do you take four or more medications?		
7	Do you have any issues with your vision?		
8	Do you get light headed or dizzy?		
9	Do you have any recurrent foot pain?		
10	Do you need to rush to the toilet?		
11	Have you been in hospital in the last 6 months?		
12	Have you had any changes in your thinking or memory?		