Advanced Internal Medicine PAULINE MILLER, MD

FALL RISK ASSESSMENT

PATIENT NAME: ________________________________ **DOB:** ________________________

DATE: _____________________________ **INSURANCE CARRIERT:** ___________________

1. **Have you fallen in the past 12 months? YES/NO**
2. **Do you have any dizziness? YES/NO**
3. **Do you ever feel imbalanced? YES/NO**

1. **Se ha caido en los ultimos 12 meses? SI/NO**
2. **Ha sentido mareos? SI/NO**
3. **Ha sentido que pierdes el equilibrio? SI/NO**