FALL RISK ASSESSMENT FORM

Have you had two or more falls in the last year?

☐ YES ☐ No

Have you had a fall resulting in an injury in the last year?

☐ YES ☐ No

Does your home have, Please check all that apply:

☐ Steps

☐ Throw rugs

☐ Unlit areas

☐ Grab bars in bathroom

Do you take?

☐ Opioids

☐ Muscle relaxers

☐ Medication for sleep

Have you had an eye exam this year?

☐ YES ☐ NO

OTHER
COMMENTS:_____
_____
_____
_____
_____
_____
_____

SIGNATURE _____ DATE_____