Fall Prevention Balance and Dizziness Survey

Patient Name: _____ **Age:** _____ **Date:** _____

To help determine if you may be headed for a fall or have a balance disorder, take the Balance Self Test below. If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he or she may help determine the cause of your symptoms.

Please read each question and check the box that most describes your answer.	**Yes or Often**	**Some-times**	**No or Never**
1. Have you fallen more than once in the past year without an obvious cause?			
2. Do you ever fall or feel like you are about to fall for no apparent reason?			
3. Do you fear falling or are you worried about losing your balance?			
4. Have you experienced dizziness, vertigo, or serious imbalance in the past six months?			
5. Do you feel unsteady when you are walking or climbing stairs?			
6. Do you feel dizzy while sitting down or rising from a seated or lying position?			
7. Does walking down the aisle of a supermarket or stopping next to moving traffic make you dizzy?			
8. Does moving your head quickly make you dizzy or cause you to feel nauseous?			
9. Are you dizzy or unsteady when you first get up in the morning?			
10. Have you continued to experience dizziness after an injury or accident?			
11. Do you use or have you ever been advised to use a walker, cane, or any other form of assistance for your mobility?			
12. Have you had a recent loss of, or decrease in, your vision or hearing?			
13. Does dizziness or imbalance interfere with your job or your household responsibilities?			
14. Has your balance problem caused problems in your social life?			
15. Do you ever lose your balance or feel dizzy or unsteady?			
16. Do you steady yourself by holding onto furniture when walking at home?			

Please fill out the top with your name and date, sign the survey at the bottom and provide this to your physician during your visit.

_____ Patient Signature

_____ Phone