# How Safe Are You From Falling?

There are a number of ways in which your risk of falling can be reduced.

Your doctor will be able to advise you about these.

Please take a few minutes to complete this questionnaire and show it to your doctor on your next visit.

**Please place a tick in the relevant circle.**

## My History of Falling

| | | | |
|---|---|---|---|
| I have had a fall in the last year: | **O Yes** | **O No** | **O Don't Know** |
| *If **Yes***, I fell | **O Inside my home** | | **O Outside my home** |

## About My Medications

| | | | |
|---|---|---|---|
| I am taking four or more medications | **O Yes** | **O No** | **O Don't Know** |
| I am taking sleeping tablets, tranquillisers or antidepressants | **O Yes** | **O No** | **O Don't Know** |
| It has been more than 12 months since my doctor reviewed my medications | **O Yes** | **O No** | **O Don't Know** |

## About My Levels Of Exercise

| | | | |
|---|---|---|---|
| I do not exercise regularly (3 times a week for 30 minutes per day) | **O Yes** | **O No** | **O Don't Know** |

## About My Balance and Walking

| | | | |
|---|---|---|---|
| I have difficulty getting up from a chair | **O Yes** | **O No** | **O Don't Know** |
| I have poor balance when walking | **O Yes** | **O No** | **O Don't Know** |

## About My Health Conditions

I have or previously have had the following health conditions:

| | | | |
|---|---|---|---|
| Problems with my heart or circulation | **O Yes** | **O No** | **O Don't Know** |
| A stroke | **O Yes** | **O No** | **O Don't Know** |
| Arthritis | **O Yes** | **O No** | **O Don't Know** |
| Parkinson's Disease | **O Yes** | **O No** | **O Don't Know** |
| Dizziness or Funny Turns | **O Yes** | **O No** | **O Don't Know** |
| Having to rush to the toilet or incontinence | **O Yes** | **O No** | **O Don't Know** |

## About My Vision

| | | | |
|---|---|---|---|
| I have poor vision | **O Yes** | **O No** | **O Don't Know** |
| It has been more than 12 months since my eyes were tested | **O Yes** | **O No** | **O Don't Know** |

If you answered **YES** to one or more of the above questions you may be at increased risk of falling. Please take this questionnaire to your doctor so that you can discuss ways to reduce the risk.

If you would like more information about this project please contact:

***Prevent Falls : Stay on Your Feet***

This information can be provided in alternative formats. For further information please contact the Southern Grampians & Glenelg Primary Care Partnership on phone: (03) 555 18471

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