

Community Pharmacy Fall Risk Checklist

Patient:	
Date of Birth:	Date:

Fall Risk Factor(s) Identified

FALL HISTORY	PRESENT?		NOTES
Any falls in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Worries about falling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Feels unsteady when standing or walking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
POSTURAL HYPOTENSION			
Patient-reported symptoms of lightheadedness or dizziness from lying to standing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

MEDICATION CLASSES WITH FALL RISK	MEDICATION(S) Include medication name, dosage prescribed, and administration directions.	PRESCRIBED BY:
Anticonvulsants		
Antidepressants		
Antihypertensives		
Antipsychotics		
Antispasmodics		
Benzodiazepines		
Opioids		
Sedative hypnotics		
Tricyclic antidepressants		
Other (e.g., OTC agents)		

Notes: