Patient Name: _____ Date of Birth:_____

ANNUAL PATIENT QUESTIONAIRE

1. Have there been any changes in your feet since your last evaluation? □ Yes □ No
   If yes, please describe _____
   _____

2. When was the last time you saw your primary care doctor? _____

3. Are you diabetic? □ Yes (Type 1 or Type 2) □ No (continue to #4)
   What was your blood sugar this morning? _____
   When is the last time you had your A1C checked? _____ What was your result? _____

4. Do you have any current ulcers or history of ulcers? □ Yes □ No
   _____

FALL RISK SELF-ASSESSMENT

In the past 12 months, I . . .

□ Yes □ No Fell two or more times.

□ Yes □ No Was injured by a fall that limited my regular activities for at least one day.

□ Yes □ No Saw a doctor because I had a fall.

□ Yes □ No Found it to be hard to climb stairs or walk a short distance.

□ Yes □ No Had trouble getting up from a soft chair.

□ Yes □ No Have been unable to stand on one foot for 12 seconds without losing my balance.

□ Yes □ No Trouble with my eyesight.

□ Yes □ No Felt dizzy or lightheaded after a big meal.

□ Yes □ No Took medication that caused me to feel dizzy or lightheaded.

□ Yes □ No Took 9 or more different medications

□ Yes □ No Stopped some of my regular activities.

□ Yes □ No Have been taking a calcium supplement regularly. If "Yes," how much per day: _____

□ Yes □ No Have NOT had my vitamin D level in my blood checked.

□ Yes □ No Danced, exercised, or practiced Tai Chi at least 3 times a week.

□ Yes □ No Had my home checked for any dangers and modified as needed.

Date Completed: _____