SOUTHWEST IDAHO
HEARING & BALANCE
A Division of Southwest Idaho Ear Nose and Throat, P.A.

DESMOND FALL RISK QUESTIONNAIRE

Name _____ Date _____

	YES	NO	
1.	☐	☐	Have you had a fall or near fall in the past year?
2.	☐	☐	Do you have a fear of falling that restricts your activity?
3.	☐	☐	Do you experience dizziness or a sensation of spinning when you lie down, put your head back or roll over in bed?
4.	☐	☐	Do you feel uneasy or unsteady when walking down the aisle of a supermarket or in an area congested with other people?
5.	☐	☐	Do you have difficulty walking in the dark or on uneven surfaces such as gravel or a sloped sidewalk?
6.	☐	☐	Do your feet or toes frequently feel unusually hot, cold, numb or tingly?
7.	☐	☐	Do you wear bifocal or trifocal glasses, or is your vision notably better in one eye?
8.	☐	☐	Do you experience loss of balance or a lightheaded/faint feeling when you stand up?
9.	☐	☐	Do you take medication for depression, anxiety, nerves, sleep or pain?
10.	☐	☐	Do you take four or more prescription medications daily?
11.	☐	☐	Do you feel like your feet just won't go where you want them to go?
12.	☐	☐	Do you feel like you can't walk a straight line or are pulled to the side while walking?
13.	☐	☐	Has it been longer than six months since you participated in a regular exercise program?
14.	☐	☐	Do you feel that no one really understands how much dizziness and balance problems affect your quality of life?
15.	☐	☐	Are you interested in improving your balance and mobility?