DALLAS HEALTH
PARTNERS

Welcome to our Practice

Your health is our primary concern. We wish to take a moment and welcome you to our practice!

Thank you for entrusting us with your care. We look forward to serving you and strive to treat every patient with dignity and respect. In order to provide continuity of care, our patients are able to select a personal clinician who works with our entire healthcare team to provide you with comprehensive, high-quality care. To reach this goal our skilled professionals take a personalized approach to care by sitting down with you and discussing your healthcare needs, goals and treatment options. We treat a full spectrum of both acute illnesses and chronic conditions.

In order to expedite the new patient registration process, we ask that you read and/or complete the following forms:

- Patient Registration/Intake Form
- Medical Health History
- Office Policy Notice to Patients
- Acknowledgement of Receipt of Notice of Privacy Practices

For your first appointment, please bring completed copies of the above forms, as well as:

- Insurance card(s)
- Photo ID
- A list of current medications and dosage
- Co-payment (if required by your insurance)

For new patients, we respectfully ask that you arrive **15** minutes prior to your scheduled appointment time with your completed paperwork. In the event that you are unable to complete this paperwork ahead of time, please arrive 30 minutes ahead of your appointment. In consideration of all of our patients, any patient who arrives **15** minutes after his or her scheduled appointment time may be asked to reschedule.

If you have a non-life threatening emergency after office hours, please call our office and the answering service will page the appropriate physician. If you are having an emergency, please call 911.

Again, thank you for choosing us. We look forward to seeing you and will do our best to make your visit as pleasant, efficient and complete as possible.

DALLAS HEALTH
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PATIENT REGISTRATION

Patient's legal name: _____ _____
Last First M.I. (Maiden)

Preferred or other known-by name: _____

Home address: _____
Street City State Zip

Social Security number: _____ / ___/_____ **Date of birth:** ___/____ / _____ **Sex:** F ☐ M ☐

Home phone: (___) _____ **Cell phone:** (___) _____ **Work phone:** (___)_____

Email: _____

How would you prefer to receive appointment reminders? ☐ phone ☐ email ☐ text

Emergency contact: _____
Last First Relationship Phone

ACKNOWLEDGMENT OF RECEIPT OF ADVANCE DIRECTIVE INFORMATION

(Living Will or Power of Attorney)

An advanced health care directive, also known as living will, personal directive, advance directive or advance decision, is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity. In the U.S., it has a legal status in itself, whereas in some countries it is legally persuasive without being a legal document.

Please initial after each statement:

I have completed an ADVANCE DIRECTIVE for health care:	☐ Yes	☐ No
If yes, please indicate which:	☐ Living Will	☐ Durable Power of Attorney
I am requesting information regarding ADVANCE DIRECTIVES:	☐ Yes	☐ No

Patient Signature: _____ Date: _____

DALLAS HEALTH
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INSURANCE INFORMATION

Primary Medical Insurance	**Secondary Medical Insurance**
Insurance Carrier: _____	_____
Carrier's Phone Number: _____	_____
Policy #: _____	_____
Group #: _____	_____
Subscriber: _____	_____
Subscriber's Soc. Sec. #: _____	_____
Relationship to Patient: _____	_____

If you are currently uninsured please complete the following:

Person responsible for payment:

Name: _____ _____
Last First M.I. Relationship

Address: _____
Street City State Zip

Certification Statement: I certify that the information above is true and accurate to the best of my knowledge.

_____
Name of Patient (Print)

_____ _____ _____
Name of Responsible Party (Print) Signature of Responsible Party Signature Date

_____
Responsible Party Driver's License #

DALLAS HEALTH
PARTNERS

OFFICE POLICY NOTICE TO PATIENTS

We strive to provide you the best personalized care available. To make this possible, we adhere to a set of very important guidelines. Please read them carefully, initial all the lines and indicate your agreement by signing at the bottom.

_____**Late Policy:** Being 15 minutes late for an appointment may require you to either reschedule or wait for an available opening. New patients should arrive 30 minutes prior to their first appointment to complete paperwork. **After 2 late visits, you will be charged $25 for each additional late visit.**

_____**Cancellation and No-Show Policy:** If you wish to change or cancel an appointment, we ask that you please provide 24 hour advance notice. This allows us to offer your appointment to another patient who may be waiting to see a physician. We understand, however, that emergencies can and do happen, and we will make every attempt to work with you. Please call as soon as you know you cannot make your scheduled appointment time. If you miss your appointment without notice, it will be considered a no-show. **We will charge $25 for a no-show appointment.** Patients who repeatedly no-show may be dismissed from the practice.

_____ **Pain Medications:** Our primary care physicians are not pain management providers and therefore do not guarantee any form of pain medications and/or narcotics. If you have a chronic condition that requires long-term use of such medications, please be advised we may refer you to a pain management clinic for treatment of the chronic pain condition.

_____ **Insurance/Co-Pays:** Please bring updated insurance and co-payment to every visit. Failure to make co-payment at the time of visit could result in cancellation of the scheduled appointment. Patients are responsible for charges not covered by insurance.

_____ **Missing proper identification:** Patients without valid photo ID, proper insurance information or missing insurance information, may be asked to reschedule. Any patient who misrepresents themselves by using out-dated or someone else's identification may be dismissed from the practice.

_____ **Self-pay:** If you are a true self pay patient without insurance, a 25 percent discount will be applied to medically necessary services. Elective and cosmetic procedures receive no discount. If, for any reason, you have insurance but request an office visit be processed as a self-pay you will not be eligible for the discount.

Patient signature:_____ Date: _____

DALLAS HEALTH
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MEDICAL PATIENT/HEALTH HISTORY

Past Medical History

Please check all that apply.

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Blood clots
- ☐ Cancer
- ☐ Chest pain
- ☐ Circulation problems
- ☐ Crohn's disease
- ☐ CVA (stroke)
- ☐ Depression
- ☐ Diabetes
- ☐ Enlarged prostate
- ☐ Gallbladder disease
- ☐ Heart failure
- ☐ Heartburn
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung Disease/ Emphysema
- ☐ Mental illness
- ☐ Migraine headaches
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Thyroid disorder
- ☐ Seizure disorder
- ☐ Ulcers
- ☐ Valve disease

Past Surgical History

Please list all prior surgeries. Include dates and any complications.

1. _____

2. _____

3. _____

4. _____

5. _____

Immunizations

Please list the last date of the below immunizations. Approximate dates are fine. Please provide a copy of childhood immunizations for patients 18 years of age or younger.

Date of last flu shot: _____/_____ / _____ ☐ None ☐ I'm not sure

Date of last pneumonia shot*: _____/_____ / _____ ☐ None ☐ I'm not sure

* Type: _____

Date of last tetanus shot: _____/_____ / _____ ☐ None ☐ I'm not sure

Date of last shingles shot: _____/_____ / _____ ☐ None ☐ I'm not sure

Additional vaccines: _____/_____ / _____ ☐ None ☐ I'm not sure

DALLAS HEALTH
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Medications

List any prescription, herbal or over-the-counter medications that you are currently taking.

Medication name*	Strength	Dosage/Directions
Example: Aspirin	325mg	1 tab daily

* *If you need more room to list your medications, please write down your other medications on a seperate piece of paper and bring it with you to your appointment.*

Please list your preferred pharmacy name and phone number: _____

_____

Do you have allergies to medications? ☐ Yes ☐ No

If yes, please list drug(s) and reactions(s): _____

_____

_____

_____

Health Maintenance

Date of last physical/preventative medical exam: _____

Are you receiving alternative care? ☐ Yes ☐ No

If yes, kind: ☐ Acupuncture ☐ Chiropractic ☐ Other: _____

Do you see a dentist on a regular basis? ☐ Yes ☐ No Date of last dental exam: ___/___/____

Adults only: Date of last cholesterol test? ___/___/_____

Adults ages 50+
date of last colonoscopy: ___/___/_____

Adults ages 65+
last osteoporosis screening (Dexa Scan): ___/___/_____

Women ages 21+ last pap smear: ___/___/_____

Women ages 40+ last mammogram: ___/___/_____

Men ages 40+ last prostate exam: ___/___/_____

DALLAS HEALTH
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Family History

Please indicate if your mother, father or sibling has any of the following diseases now or if it was their cause of death (COD). Please also indicate if aunt/uncle/grandparents in the "other" box. Check all that apply. If you are not sure, please place a question mark (?) in those boxes

	MOTHER		FATHER		SISTER(S)		BROTHER(S)		OTHER		
	Yes	COD	Yes	COD	Yes	COD	Yes	COD	Yes	COD	Relationship
Diabetes											
Heart disease											
High blood pressure											
High cholesterol											
CVA (stroke)											
Kidney disease											
Alcoholism											
Alzheimer's disease											
Asthma											
Blood clots											
Cancer											
Circulation problems											
Depression/anxiety											
Development delays											
Eczema											
Irritable bowel disease											
Mental illness											
Migraines											
Obesity											
Seizure disorder											
Substance abuse											
Other family history											

Social History

Check all that apply.

Do you have good family support? ☐ Yes ☐ No

Do you feel safe at home? ☐ Yes ☐ No

Any religious or cultural needs that you would like our medical practice to know? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

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Tobacco Use History

Uses tobacco: ☐ Currently ☐ Formerly ☐ Never

Tobacco type: ☐ Cigarettes ☐ Chewing ☐ Cigar ☐ Pipe ☐ Snuff ☐ Other_____

Amount per day: _____ (packs, ounces, cigars, pipes) Number of years: _____

Tobacco cessation ever discussed: ☐ Yes ☐ No

Secondary smoke exposure: ☐ Yes ☐ No

Alcohol Use History

Drinks alcohol: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely ☐ Never

Type: _____

Caffeine Use History

Drinks Caffeine: ☐ Coffee ☐ Pop ☐ Tea ☐ Energy Drinks

How many daily: _____

Illegal Drug Use History

Uses illegal drugs: ☐ Currently ☐ Formerly ☐ Never

If currently or formerly please indicate drugs used: _____

Have you ever sought treatment for drug use: ☐ Yes ☐ No

Sexual History

Do you have any concerns about possible exposure to sexually transmitted diseases that you would like to discuss or be tested for? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No Do you engage in risky sexual behavior? ☐ Yes ☐ No

Have you ever been treated for a sexually transmitted disease? ☐ Yes ☐ No

How do you identify yourself? ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Prefer not to answer

Exercise History

Exercise Frequency:

☐ Occasionally ☐ 2-3 times a week ☐ 3-4 times a week ☐ 5+ tmes a week

Type of exercise you prefer:

☐ Cycling ☐ Jogging/Running ☐ Tennis ☐ Weights ☐ Golf

☐ Swimming ☐ Walking ☐ Yoga ☐ Other: _____

DALLAS HEALTH
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AUTHORIZATION TO DISCUSS PERSONAL HEALTH INFORMATION WITH FAMILY AND FRIENDS

Date:	Name	Relationship to Patient	Phone	Specific Visit, Procedure or Diagnosis	Restrictions: Visit, Procedure Diagnosis	Date Revoked
*						

* Indicates emergency contact

You have my permission to discuss my personal health information with the individuals designated above. This authorization will be effective on the date below and will remain in effect until revised or revoked. This authorization can be revoked at any time, either verbally or in writing.

_____ _____ _____

Patient Signature | Patient Representative | Signature Date

Reviewed and/or Revised

Date	Signature

Date	Signature

Date	Signature

DALLAS HEALTH PARTNERS

OUR PATIENT CARE PARTNERSHIP

Understanding Expectations, Rights and Responsibilities

Our commitment to you:

- We are committed to treating and using your protected health information responsibly.
- Under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), you have certain rights to privacy regarding your protected health information.
- This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 1, 2003, and applies to all protected health information as defined by federal regulations.
- Each time you visit Dallas Health Partners, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment, means of communication among the many health professionals who contribute to your care, legal document describing the care you received, means by which you or a third-party payer can verify that services billed where actually provided, a tool in educating health professionals, a source of data for medical research, a source of information for public health officials charged with improvising the health for this state and the nation, a source of data for our planning and marketing, and a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.
- Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

We promise to:

- Maintain the privacy of your health information.
  Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a request restriction, and accommodate reasonable requests you may have communicate health information by alternative means or at alternative locations.
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

As a patient, you have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health records as provided for in 45 CFR 164.524.
- Amend your health records as provided in 45 CFR 164.528
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 and revoke your authorization to use or disclose health information

As a patient, you have the right to:

- Effective communications in a manner you understand.
- Considerate and respectful care, including the right to be free from all forms of harassment, neglect, exploitation, and verbal, mental, physical and sexual abuse.
- Receive care regardless of your age, race, ethnicity, religion, culture, language, sex, national origin, sexual orientation, physical or mental disability, gender identity or expression, socioeconomic status, or source of payment.
- Have a support person, such as a family member, friend or other individual of your choosing, present with you at your visits.
- Legally appoint someone else to make decisions for you if you become unable to do so, and have that person approve or refuse care.
- Have your complaints addressed and receive resolution within a timely, reasonable and consistent manner
- Confidentiality, personal privacy and security

As a patient, you have the responsibility to:

- Provide information about past illness, hospitalizations, medications, and other matters related to your health, including changes in your symptoms or condition.
- Inform your care providers when information has not been understood.
- Follow the recommendations and advice of your care providers, and understand that you are responsible for the consequences if you refuse to do so.
- Provide complete and accurate information about insurance and your ability to meet the financial obligations of your care.
- Be considerate and respect the rights and property of other patients, visitors, and clinic staff.

Notice of Privacy Practices:

- I have had the opportunity to review the Notice of Privacy Practices above.
- I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.
- I understand that I may request in writing that you restrict how my private information is used or disclosed. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name (print): _____

Signature: _____

Relationship to Patient (if applicable): _____

Date: _____

DALLAS HEALTH
PARTNERS

PHYSICIAN ASSISTANT CONSENT FORM

This facility has on-staff physician assistants to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases, as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather requires overseeing all activities and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Developing and implementing a treatment plan
- Formulation of a working diagnosis
- Monitoring the effectiveness of therapeutic interventions
- Assisting at procedures
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant for my health care needs. I understand that at any time I can refuse to see the physician assistant and request to see a physician.

_____ _____

Name Date

_____ _____

Signature Witness (Optional)

DALLAS HEALTH
PARTNERS

CHRONIC CARE MANAGEMENT CONSENT FORM

Medicare requires our patients to sign a consent form allowing us to talk to you over the phone about your medical conditions in an effort to perform chronic care management.

By signing this Agreement, you consent to **Dallas Health Partners** (referred to as "Provider"), providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you when you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which then place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Dallas Health Partners to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. Provider will discuss with you the specific services that will be available to you and how to access those services.

Providers's Obligation:

When providing CCM Services, the Provider must:

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgment and Authorization:

By Signing this Agreement, you agree to the following:

- You consent to Provider providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.

- You acknowledge that only one practitioner can furnish CCM Services to you during a thirty (30) day period.
- You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.
- You understand that you will be responsible for any associated copayment or deductible relating to CCM Services

Beneficiary Rights:

You have the following rights with respect to CCM Services:

- Provider will provide you with written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty (30) day period of services. You may revoke this agreement verbally (by calling 214-823-4200) or in writing (3600 Gaston Ave, Wadley Tower #755, Dallas, Texas 75246). Upon receipt of your revocation, Provider will give you written confirmation (including the effective date) of revocation.

BENEFICIARY (or Beneficiary's Representative/Caregiver)

Print Name: _____

Signature: _____

Date: _____

Relationship to Beneficiary (if applicable): _____

MEDICARE WELLNESS CHECKUP

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

Your name: _____

Today's date: _____

Your date of birth: _____

1. What is your age?

☐ 65-69. ☐ 70-79. ☐ 80 or older.

2. Are you a male or a female?

☐ Male. ☐ Female.

3. During the **past four weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

4. During the **past four weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

5. During the **past four weeks**, how much bodily pain have you generally had?

☐ No pain.
☐ Very mild pain.
☐ Mild pain.
☐ Moderate pain.
☐ Severe pain.

6. During the **past four weeks**, was someone available to help you if you needed and wanted help?

(For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

☐ Yes, as much as I wanted.
☐ Yes, quite a bit.
☐ Yes, some.
☐ Yes, a little.
☐ No, not at all.

7. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

☐ Very heavy.
☐ Heavy.
☐ Moderate.
☐ Light.
☐ Very light.

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)

☐ Yes. ☐ No.

9. Can you go shopping for groceries or clothes without someone's help?

☐ Yes. ☐ No.

10. Can you prepare your own meals?

☐ Yes. ☐ No.

11. Can you do your housework without help?

☐ Yes. ☐ No.

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

☐ Yes. ☐ No.

13. Can you handle your own money without help?

☐ Yes. ☐ No.

14. During the **past four weeks**, how would you rate your health in general?

☐ Excellent.
☐ Very good.
☐ Good.
☐ Fair.
☐ Poor.

continued ➤

15. How have things been going for you during the **past four weeks**?

- ☐ Very well; could hardly be better.
- ☐ Pretty well.
- ☐ Good and bad parts about equal.
- ☐ Pretty bad.
- ☐ Very bad; could hardly be worse.

16. Are you having difficulties driving your car?

- ☐ Yes, often.
- ☐ Sometimes.
- ☐ No.
- ☐ Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?

- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No.

18. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up.	☐	☐	☐	☐	☐
Sexual problems.	☐	☐	☐	☐	☐
Trouble eating well.	☐	☐	☐	☐	☐
Teeth or denture problems.	☐	☐	☐	☐	☐
Problems using the telephone.	☐	☐	☐	☐	☐
Tiredness or fatigue.	☐	☐	☐	☐	☐

19. Have you fallen two or more times in **the past year**?

☐ Yes. ☐ No.

20. Are you afraid of falling?

☐ Yes. ☐ No.

21. Are you a smoker?

- ☐ No.
- ☐ Yes, and I might quit.
- ☐ Yes, but I'm not ready to quit.

22. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

- ☐ 10 or more drinks per week.
- ☐ 6-9 drinks per week.
- ☐ 2-5 drinks per week.
- ☐ One drink or less per week.
- ☐ No alcohol at all.

23. Do you exercise for about 20 minutes three or more days a week?

- ☐ Yes, most of the time.
- ☐ Yes, some of the time.
- ☐ No, I usually do not exercise this much.

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

☐ Yes. ☐ No.

Keeping track of your medications?

☐ Yes. ☐ No.

25. How often do you have trouble taking medicines the way you have been told to take them?

- ☐ I do not have to take medicine.
- ☐ I always take them as prescribed.
- ☐ Sometimes I take them as prescribed.
- ☐ I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?

- ☐ Very confident.
- ☐ Somewhat confident.
- ☐ Not very confident.
- ☐ I do not have any health problems.

27. What is your race? (**Check all that apply.**)

- ☐ White.
- ☐ Black or African American.
- ☐ Asian.
- ☐ Native Hawaiian or other Pacific Islander.
- ☐ American Indian or Alaskan Native.
- ☐ Hispanic or Latino origin or descent.
- ☐ Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

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