HEALTH & ACTIVITY QUESTIONNAIRE

Name: _____ Date: _____

1. **How many times have you fallen within the past year?** ____

2. **Do you wear eyeglasses or contacts?** ☐ Yes ☐ No

3. **Do you use hearing aids?** ☐ Yes ☐ No
   If YES, in which ear? ☐ Left ☐ Right ☐ Both

4. **Do you use an assistive device for walking?** ☐ Yes ☐ No ☐ Sometimes

5. **Have you ever had any condition or injury that has affected your balance or ability to walk without assistance?** ☐ Yes ☐ No

6. **Have you ever been diagnosed with any of the following conditions?**

			Year Diagnosed
Heart attack	☐ Yes	☐ No	
Transient ischemic attack (aka mini-stroke)	☐ Yes	☐ No	
Angina (chest pain)	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	
Peripheral vascular disease	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Neuropathies (problems w/ sensations)	☐ Yes	☐ No	
Respiratory disease (breathing problems)	☐ Yes	☐ No	
Parkinson's disease	☐ Yes	☐ No	
Multiple sclerosis	☐ Yes	☐ No	
Polio/Post-polio syndrome	☐ Yes	☐ No	
Epilepsy/seizures	☐ Yes	☐ No	
Other neurological conditions	☐ Yes	☐ No	
Osteoporosis	☐ Yes	☐ No	
Rheumatoid arthritis	☐ Yes	☐ No	
Other arthritic conditions	☐ Yes	☐ No	
Visual/depth perception problems	☐ Yes	☐ No	
Inner ear problems	☐ Yes	☐ No	

Thank You! ☺