

PQRI Measure 4, Future Fall Risk Survey

Patient Identification Number	Survey Date	MM	DD	YYYY
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1. Have you fallen in the past year? Yes No

If "Yes" to #1, continue to #2

If "No" to #1, Stop

2. Did you sustain an injury from the fall? Yes No

If "No" to #2, continue to #3

If "Yes" to #2, Stop

3. Have you had 2 or more falls in the past year? Yes No