**Supplement 1: Full Frailty and Fall Survey**

**Frailty and Fall Survey Part I: Patient Demographics**

**Subject Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This survey will only be administered at the initial visit**

1. Age: \_\_\_\_\_\_\_\_
2. Gender:
* Male
* Female
1. Race
* American Indian or Alaska Native
* Black
* White
* Asian
* Native Hawaiian/Pacific islander
* Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. Ethnicity
* Hispanic
* Non-Hispanic
1. Marital Status
* Never married
* Widowed
* Separated
* Married
* Divorced
1. Highest grade Completed
* Grade school (grades 1-6)
* Middle school (grades 7-8)
* High school (grades 9-12)
* College or technical school
* Graduate school
1. Do you have a primary care physician?
* Yes
* No

**Frailty and Fall Survey Part II: General Health & Quality of Life**

**Subject Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Survey Number**: \_\_\_ of 5

**To be completed on enrollment and every three months post-discharge up to one year after discharge.**

1. Have you been told you have a hearing problem?
* Yes (complete part (i) below)
* No (continue to question 9)

i. Do you have hearing aids?

* Yes (complete part (ii) below)
* No (continue to question 9)

 ii. If you wear hearing aids, how much of the day do you wear them?

* All of the time
* Most of the time
* Some of the time
* A little of the time
* Never
1. Do you have problems with your vision when adjusting to changes in light or in the shadows (for example, walking inside after being outside in the sun)?
* Yes
* No
1. Do you have problems with your vision when judging the steepness of stairs or curves?
* Yes
* No
1. Do you have problems with your vision when avoiding obstacles in your path?
* Yes
* No
1. Can you walk one block?
* Yes
* No
1. Can you climb a flight of stairs?
* Yes
* No
1. Do you use a cane?
* No
* Yes, some of the time
* Yes, all of the time
1. Do you use a walker?
* No
* Yes, some of the time
* Yes, all of the time
1. Do you use a wheelchair or an electronic scooter?
* No
* Yes, some of the time
* Yes, all of the time
1. Do you currently have, or have you previously had, any of the following conditions (check all that apply):
* High blood pressure
* Heart attack
* Coronary artery bypass grafting
* Angioplasty
* Congestive heart failure
* A stroke
* Parkinson’s disease
* Cancer (other than skin cancer)
* Diabetes (problems with your sugar)
* Arthritis
* Chronic lung disease, like chronic bronchitis, emphysema, COPD, or asthma
* Osteoporosis or low bone density
* Dementia (if yes, complete part (i))

i. Is your dementia:

* Severe
* Moderate
* Mild
1. Have you experienced any of the following symptoms in the last 6 months (check all that apply):
* Poor coordination (including clumsiness, confusion over left and right, poor body awareness, and poor posture)
* Frequent periods of drowsiness or fatigue
* Back problems
* Symptoms of depression
* Dizziness or the sensation of moving while you are actually still (vertigo)
* Urinary incontinence (i.e. can you hold your water)
* Shortness of breath
* Fatigue
* Weight loss greater than 5%
1. Please list all medications you are currently taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you need help with any of the following (check all that apply):
* Grooming
* Managing money
* Doing household work
* Toileting
1. Do you feel less useful?
* Most of the time
* Sometimes
* Never
1. Do you feel sad?
* Most of the time
* Sometimes
* Never
1. Do you feel effort to do everything?
* Most of the time
* Sometimes
* Never
1. Have you experienced falls?
* Often
* Sometimes
* Never
1. Do you feel lonely?
* Most of the time
* Sometimes
* Never
1. Are you sexually active?
* Yes
* No
1. In general, would you say your health is:
* Excellent
* Very Good
* Good
* Fair
* Poor
1. Does your health currently limit you in moderate activities (i.e. moving a table, pushing a vacuum cleaner, bowling, or playing golf)? Would you say it:
* Yes, limits you a lot
* Yes, limits you a little
* No, does not limit you at all
1. Does your health now limit you in climbing several flights of stairs? Would you say it:
* Yes, limits you a lot
* Yes, limits you a little
* No, does not limit you at all
1. In the last four weeks, do you feel that you accomplished less than you would like as a result of your physical health?
* No
* Yes, a little of the time
* Yes, some of the time
* Yes, most of the time
* Yes, all of the time
1. In the last four weeks, were you limited in the kind of work or other activities you performed as a result of your physical health?
* No
* Yes, a little of the time
* Yes, some of the time
* Yes, most of the time
* Yes, all of the time
1. In the last four weeks, do you feel that you accomplished less than you would like as a result of your emotional/mental health (e.g. depression/anxiety)?
* No
* Yes, a little of the time
* Yes, some of the time
* Yes, most of the time
* Yes, all of the time
1. In the last four weeks, were you unable to do work or other activities as carefully as usual due to your emotional/mental health?
* No
* Yes, a little of the time
* Yes, some of the time
* Yes, most of the time
* Yes, all of the time
1. In the last four weeks, did pain interfere with your normal work (including both work outside the home and house work)?
* No
* Yes, a little of the time
* Yes, some of the time
* Yes, most of the time
* Yes, all of the time
1. In the last four weeks, have you felt calm and peaceful?
* No
* Yes, a little of the time
* Yes, some of the time
* Yes, most of the time
* Yes, all of the time
1. In the last four weeks, did you feel you had a lot of energy?
* No
* Yes, a little of the time
* Yes, some of the time
* Yes, most of the time
* Yes, all of the time
1. In the last four weeks, have you felt downhearted and blue?
* No
* Yes, a little of the time
* Yes, some of the time
* Yes, most of the time
* Yes, all of the time
1. In the last four weeks, has your physical or emotional health interfered with your social activities (like visiting with friends or relatives)?
* No
* Yes, a little of the time
* Yes, some of the time
* Yes, most of the time
* Yes, all of the time
1. Compared to one year ago, how would you rate your current physical health in general?
* Much better
* Slightly better
* About the same
* Slightly worse
* Much worse
1. Compared to one year ago, how would you rate your current emotional health (i.e. feelings of anxiety, depression, or irritability)?
* Much better
* Slightly better
* About the same
* Slightly worse
* Much worse

**Frailty and Fall Survey Part III: Fall History**

**Subject Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Survey Number (circle one):**

 Weekly: 1 2 3 4

 Bi-weekly: 1 2 3 4

 Monthly: 1 2 3

 Yearly: 1

1. Have you fallen in the past week?
* Yes

i. If yes, how many times have you fallen in the past week? \_\_\_\_\_\_

* No (If no, please do not complete the rest of the survey)
1. Did you need help getting up after any of your falls?
* Yes
* No
1. Did you visit the emergency room related to your fall?
* Yes

i. If yes, which emergency room did you visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* No
1. Did you see a doctor because of any falls?
* Yes
* No
1. Did any of the falls result in an injury?
* Yes

i. if yes, what injuries did you sustain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* No
1. Has falling caused you to limit any of your usual activities?
* Yes
* No
1. Has falling caused you to approach your daily life with hesitation?
* Yes
* No
1. How afraid are you that you will fall and hurt yourself?
* Not afraid at all
* A little afraid
* Fairly afraid
* Very afraid
1. How likely do you think it is that you will fall within the next six months?
* Very unlikely
* Somewhat unlikely
* Neither likely nor unlikely
* Somewhat likely
* Very likely
1. Do you think you are more or less likely to fall within the next six months compared to other people your age?
* Less likely
* No more or less likely
* More likely
1. Have you limited any of your activities due to a fear of falling?
* Yes
* No