

## Confidential Patient Health Record

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

How did you hear about us? ☐ Physician ☐ Family member ☐ Friend ☐ Close to home or work  
☐ Drove by ☐ Referred by hospital ☐ Insurance plan recommended ☐ School athletic trainer  
☐ Coach ☐ Sign or billboard ☐ Newspaper ad ☐ Internet search ☐ Other: \_\_\_\_\_

### General Information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer (if student, list name of school): \_\_\_\_\_

If your injury is sport related, list the sport, level of play, and team name: \_\_\_\_\_

Name of pediatrician, primary care physician or family physician: \_\_\_\_\_

Physician phone number: \_\_\_\_\_

### Chief Complaint

What is the reason for your visit (i.e., what is your major complaint)? (Be specific)

Describe how the injury occurred.

### History of Present Illness

Please provide the date of your most recent head injury (day/month/year): \_\_\_\_\_

|                                                           |   |   |
|-----------------------------------------------------------|---|---|
| Did your head injury result in any loss of consciousness? | Y | N |
|-----------------------------------------------------------|---|---|

|                                                                 |   |   |
|-----------------------------------------------------------------|---|---|
| Did your head injury result in any difficulty with your memory? | Y | N |
|-----------------------------------------------------------------|---|---|

|                                                             |   |   |
|-------------------------------------------------------------|---|---|
| Did your head injury result in any seizures or convulsions? | Y | N |
|-------------------------------------------------------------|---|---|

## Review of Symptoms

Are you **CURRENTLY** experiencing any of the following problems? Please circle all that apply.

|                          |                            |                         |              |
|--------------------------|----------------------------|-------------------------|--------------|
| Headache                 | Vomiting                   | Nausea                  | Dizziness    |
| Blurred vision           | "Pressure in Head"         | Sensitivity to light    | Confusion    |
| Sensitivity to noise     | Feeling slowed down        | Feeling like "in a fog" | Drowsiness   |
| Difficulty concentrating | Difficulty remembering     | Fatigue or low energy   | Sadness      |
| Feeling emotional        | Feeling nervous or anxious | Feeling irritable       | Neck pain    |
| Numbness or tingling     | Balance problems           | "Don't feel right"      | Stiffness    |
| Trouble falling asleep   | Sleeping too little        | Sleeping too much       | Hearing loss |
| Ringing in your ears     | Vertigo (room is spinning) | Loss of smell           | Facial Pain  |

Do any of the symptoms get worse with physical activity?      Yes      No

Do any of the symptoms get worse with mental activity?      Yes      No

Which of the following is this injury interfering with?    ☐ Work    ☐ School    ☐ Sleep    ☐ Daily routine    ☐ Driving

## Relevant Concussion History

How many times in the past have you had a head injury? (examples: diagnosed with a concussion, "got your bell rung", didn't feel right after a blow to the head)

0    1    2    3    4    5    6    7    8    9    10

Did any of your past head injuries result in missing days at work, school or with your sports team?

Yes      No

If applicable, list the approximate dates (month and year) of your last 3 concussions.

- 1.
- 2.
- 3.

## Relevant Past Medical or Surgical History

Have you ever received treatment for any of the following? Please circle all that apply.

Headache

Psychiatric conditions (e.g., depression, anxiety, ADD/ADHD)

Migraine

Behavioral conditions (e.g., impulsive aggression)

Epilepsy or seizure

Substance of alcohol abuse

Brain or skull surgery

Speech or language disorders

Substance or Alcohol abuse

Learning disability

List any chronic medical condition that you have been formally diagnosed with (examples: diabetes, high blood pressure, heart disease, etc.).

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List any past surgeries:

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Please list any significant family medical history along with the relationship (i.e. mother, father, grandmother):

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## Medications and Allergies

Please list **all** medications or supplements, as well as their dosages, and frequency of administration:

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Do you have any allergies?

Yes

No

If yes, list all, and the reactions you had: \_\_\_\_\_

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Concussion Center

## Social History

Have you ever smoked?

Yes

No

Currently

How much? \_\_\_\_\_

How many years? \_\_\_\_\_

Have you ever used smokeless tobacco?

Yes

No

Currently

How much? \_\_\_\_\_

How many years? \_\_\_\_\_

**Do you have any cultural, religious beliefs, or preferences about your healthcare that you would like us to know?**

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If patient is a minor, parent must also sign below)

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_