University of South Florida
Concussion Center
Patient History Form

Name: Date:

Date of Birth (Month/Day/Year): Sex: M F

Sport and/or Occupation:

Chief Complaint

What is the reason for your visit? (Be as specific as possible)

_____

_____

_____

History of Present Illness

Please provide the date of your most recent concussion (day/month/year):

Did your concussion result in any loss of consciousness? Y N

Did your concussion result in any difficulty with your memory? Y N

Did your concussion result in any seizures or convulsions? Y N

Medications and Allergies

Please list **all** medications, dosages, and frequency of administration:

Do you have any allergies? Y N

(If yes, list all)_____

Review of Symptoms

Do you currently have any of the following problems?

Please check all that apply and identify the severity on a scale 1 – 6 with 1 indicating that the problem is minor in nature and 6 that the problem is severe.

☐	Headache	1	2	3	4	5	6
☐	Vomiting	1	2	3	4	5	6
☐	Nausea	1	2	3	4	5	6
☐	Dizziness	1	2	3	4	5	6
☐	Blurred vision	1	2	3	4	5	6
☐	“Pressure in Head”	1	2	3	4	5	6
☐	Sensitivity to light	1	2	3	4	5	6
☐	Sensitivity to noise	1	2	3	4	5	6
☐	Feeling slowed down	1	2	3	4	5	6
☐	Feeling like “in a fog”	1	2	3	4	5	6
☐	Difficulty concentrating	1	2	3	4	5	6
☐	Difficulty remembering	1	2	3	4	5	6
☐	Fatigue or low energy	1	2	3	4	5	6
☐	Confusion	1	2	3	4	5	6
☐	Drowsiness	1	2	3	4	5	6
☐	Feeling emotional	1	2	3	4	5	6
☐	Feeling nervous or anxious	1	2	3	4	5	6
☐	Sadness	1	2	3	4	5	6
☐	Feeling irritable	1	2	3	4	5	6
☐	Numbness or tingling	1	2	3	4	5	6
☐	Balance problems	1	2	3	4	5	6
☐	Trouble falling asleep	1	2	3	4	5	6
☐	Sleeping too little	1	2	3	4	5	6
☐	Sleeping too much	1	2	3	4	5	6
☐	“Don’t feel right”	1	2	3	4	5	6

Do any of the symptoms get worse with physical activity? Y N

Do any of the symptoms get worse with mental activity? Y N

Relevant Past Medical or Surgical History

How many times have you been previously diagnosed with a concussion?

a. How many times did you lose consciousness with those past concussions?

b. How many times did you have memory problems associated with those past concussions?

c. Did any of your past concussions result in you missing days at work or school, or games and practices with your sports team?

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

1.
2.
3.

Have you ever received treatment for:

Headache	Y	N
Migraine	Y	N
Epilepsy or seizure	Y	N
Meningitis	Y	N
Substance or alcohol abuse	Y	N
Psychiatric conditions (e.g., depression, anxiety)	Y	N
Brain or skull surgery	Y	N

If yes, provide date and reason for surgery

_____

Personal History

Have you ever been diagnosed with a learning disability? Y N

Have you ever been diagnosed with attention deficit disorder or hyperactivity? Y N

Have you ever diagnosed with any of the following? (Circle all that apply)

Cancer	Thyroid problem	Liver disease	High blood pressure
Diabetes	Rheumatic fever	Asthma	Mitral valve prolapse
Pneumonia	Sickle cell trait	Anemia	Heart disease

Social History

Do you smoke? Y N How much? _____
How many years? _____

Do you drink alcohol? Y N How much? _____
How often? _____

Any history of recreational drug use? Y N
If so, which drugs? _____

Family History

Has anyone in your family ever received treatment for:

Headache	Y	N
Migraine	Y	N
Epilepsy or seizure	Y	N
Brain surgery	Y	N
Meningitis	Y	N
Substance or alcohol abuse	Y	N
Dementia	Y	N
Other psychiatric conditions (eg., depression, anxiety)	Y	N
Stroke	Y	N
Cancer	Y	N
Diabetes	Y	N
Asthma	Y	N
Heart Disease	Y	N
High Blood Pressure	Y	N

Review of Systems

PLEASE CIRCLE IF YOU HAVE ANY OF THE BELOW SYMPTOMS:

Constitutional – fever, weight loss, weight gain, night sweats, nausea
Eyes – blurred vision, dry eyes, double vision, loss of vision, pain with eye movement
Cardiovascular – heart disease, chest pain, palpitations, swelling of the feet and legs
Respiratory – cough, difficulty breathing, shortness of breath
Gastrointestinal – abdominal pain, diarrhea, constipation, bloody stools
Genitourinary – painful urination, blood in the urine, frequent urination
Musculoskeletal – joint pain, muscle pain, joint swelling, joint stiffness
Skin – rashes, bites
Neurological – headaches, dizziness, poor coordination, numbness, tingling, back pain, neck pain, weakness, difficulty walking,
Psychiatric – depression, anxiety, mood disorders
Endocrine – intolerance to heat or cold, thyroid dysfunction
Hematologic – easy bruising, bleeding, clotting problems, history of blood transfusions
Allergy – seasonal or environmental allergies
Infectious – HIV, Hepatitis A, B or C

Other: _____

_____

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____