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 (e.g., 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:______________