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.).

____

____

List any past surgeries:

____

____

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

____

____

____

Medications and Allergies

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

____

____

____

Do you have any allergies? Yes No

If yes, list all, and the reactions you had: ____

____

____

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?

____

____

Patient Signature: ____ Date: _______________

(If patient is a minor, parent must also sign below)

Parent Signature: ____ Date: _______________

Physician Signature: ______________________________________ Date: _______________

USF HEALTH Concussion Center