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** ☐ **Other:** _____

General Information

Last name: _____ First name: _____ Middle: _____

Home Address: _____

Birth Date:_____/_____/_____ Age: _____ Sex: _____

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: _____

Address (if available): _____

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.

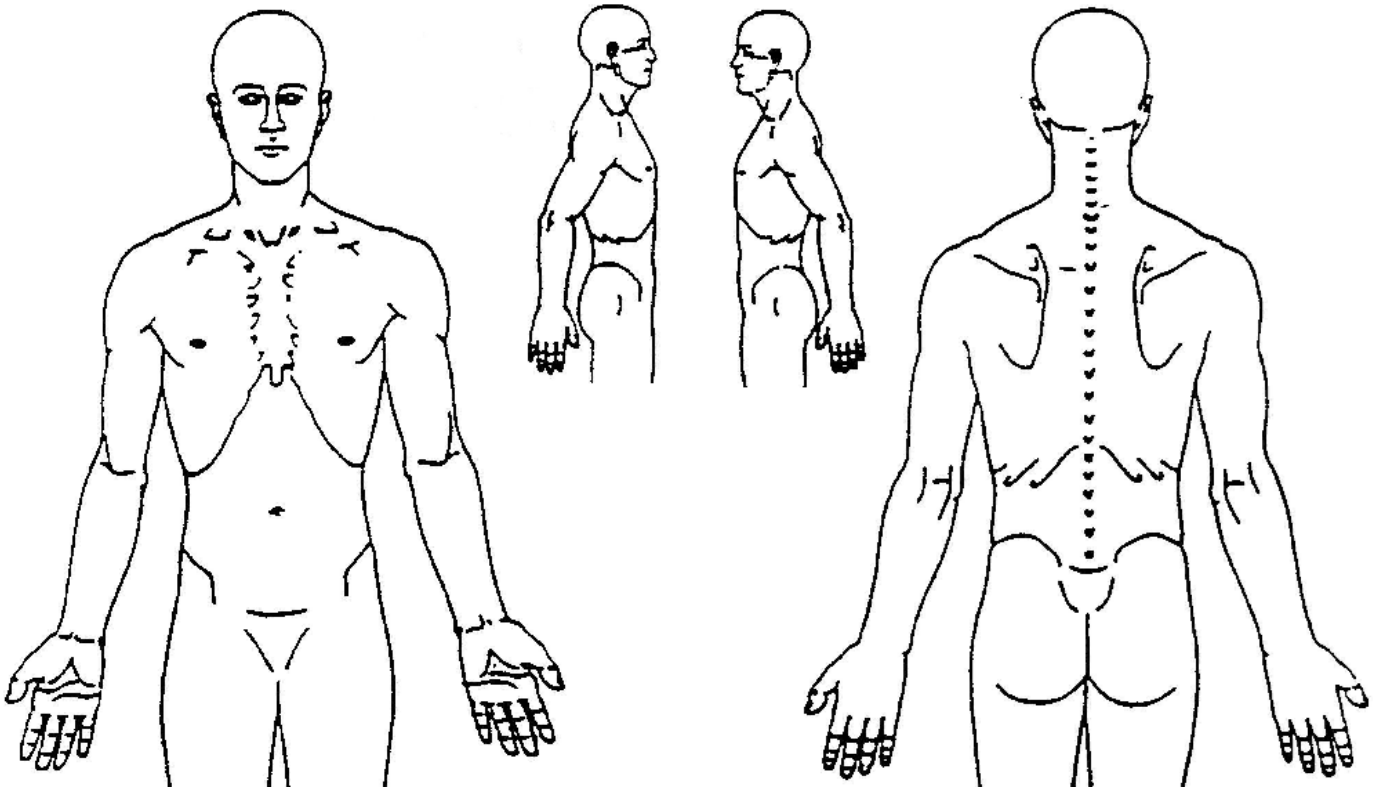
History of Present Illness

Please provide the date of your most recent 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

Location of Impact

Please identify with an ‘X’ where you struck your head, if applicable.



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

Which ones?

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

Which ones?

Is this injury interfering with your: ☐ Work ☐ School ☐ Sleep ☐ Daily routine ☐ Other_____

Are you concerned that your symptoms will make it difficult to return to your normal activities? Yes No

Relevant Concussion History

Circle how many times have you been previously diagnosed with a concussion.

1 2 3 4 5 6+

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

1 2 3 4 5 6+

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

1 2 3 4 5 6+

c. Did any of your past concussions result in you missing days at work or 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:

Headache	Yes	No
Migraine	Yes	No
Epilepsy or seizure	Yes	No
Brain or skull surgery	Yes	No
Meningitis or encephalitis	Yes	No
Substance or alcohol abuse	Yes	No
Speech or language disorders	Yes	No
Psychiatric conditions (e.g., depression, anxiety, ADD/ADHD)	Yes	No
Behavioral conditions (e.g., impulsive aggression)	Yes	No
Learning disability	Yes	No
Behavioral conditions (e.g., impulsive aggression)	Yes	No

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

_____

_____

_____

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: _____

_____

Social History

Do you smoke? Yes No How much? _____

How many years? _____

Do you drink alcohol? Yes No How much? _____

How often? _____

Any history of recreational drug use? Yes No

If so, which drugs? _____

Family History

Has anyone in your family ever received treatment for:

Headache	Yes	No
Migraine	Yes	No
Epilepsy or seizure	Yes	No
Brain surgery	Yes	No
Meningitis	Yes	No
Substance or alcohol abuse	Yes	No
Dementia	Yes	No
Other psychiatric condition (e.g., depression, anxiety, ADD/DHD)	Yes	No
Stroke	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Heart disease	Yes	No
High blood pressure	Yes	No

Other (please list)_____

Review of Systems

PLEASE CHECK IF YOU CURRENTLY HAVE ANY OF THE SYMPTOMS LISTED BELOW:

Constitutional fever ☐ weight loss ☐ weight gain ☐ night sweats ☐ nausea ☐

Eyes 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 ☐ muscle weakness ☐

Skin rashes ☐ bites ☐ infections ☐

Neurological poor coordination ☐ back pain ☐ neck pain ☐ any loss of sensation ☐

Psychiatric depression ☐ anxiety ☐ mood disorders ☐ post-traumatic stress disorder ☐

Endocrine intolerance to heat or cold ☐ thyroid dysfunction ☐

Hematologic easy bruising ☐ bleeding ☐ clotting problems ☐ history of blood transfusions ☐

Allergy seasonal or environmental allergies ☐ food allergies ☐

Infectious HIV ☐ Hepatitis A ☐ B ☐ or C ☐

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: _____