Concussion Patient Medical History

Name ________________________________ Age _______ Date of Birth ___/____/_____ Date ___/___/_____
School (students only)______________________ Who referred you? ____
Personal Physician ________________________ Physician's Address ______________________________________

When did the concussion occur? (Date and time) ____

Please give details about how your concussion occurred. ____
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What types of treatment(s) if any have you tried for your concussion? _______________________________
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What diagnostic studies have been done for this problem? **PLEASE CIRCLE**. CT Scan MRI EEG
On a scale of 1-10 (10=worst) how would you rate your pain? (**CIRCLE ONE**) 1 2 3 4 5 6 7 8 9 10
Is your pain getting (**CIRCLE ONE**): Getting better Getting Worse Staying the Same
What makes your pain worse? ____
What makes your pain better? ____
Where is your headache/pain located? ____
Describe your headache. ____

Current Medications (including vitamins)	Allergies (type of reaction)

Please **CIRCLE** all that apply:

Tobacco use Alcohol use Street drug use Caffeine use

Does your family have any of the following medical conditions? Please list relation.

Heart Disease	
Sudden Death	
Hypertension (high blood pressure)	
High Cholesterol	
Diabetes	
Cancer	
Lung Disease	

Other Current Medical Problems (for which you are under treatment)	

Hospitalizations and Surgeries			
Date	Reason	Date	Reason

Medical History (please "O" all PRESENT conditions and "X" all PAST conditions):					
HEENT		**RESPIRATORY**		**MUSCULOSKELETAL**	
Headaches		Asthma		Herniated Disc Location:	
Migraines		Bronchitis			
Concussion		Pneumonia		Broken bones Specify:	
Head injury		Short of breath w/ exercise			
Eye problems		Coughing during / after exercise		Chronic back pain	
Wear glasses / contacts		Use an inhaler		Chronic neck pain	
Last eye exam:		**GASTRO-INTESTINAL**		Joint pain Specify:	
Hearing problems		Heartburn / indigestion			
Sinus problems		Ulcers		Whiplash injury	
Frequent colds		Diarrhea		Shoulder injury	
CARDIOVASULAR		Constipation		Knee injury	
High blood pressure		Gall bladder problems		Sprained ankle	
Angina		Use antacids		Wear orthotics in shoes	
Chest pain with exertion		Hemorrhoids		Scoliosis	
Palpations		Irritable bowl		Tendonitis	
Irregular heart beat		Colitis / Crohn's Disease		Bursitis	
Heart failure		Blood in stool/black tarry stool		Rheumatoid arthritis	
Get lightheaded/faint w/ exercise		Diverticulosis / Diverticulitis		Short leg	
Heart murmur		Excess gas / bloating		Osteoporosis	
High cholesterol		**GENITOURINARY**		**ENDOCRINE**	
Stroke		Frequent urinary infections		Diabetes (insulin-dependent)	
Aneurysm		Kidney stones		Diabetes (non-insulin dependent)	
Phlebitis / blood clots in legs		Prostate trouble (men only)		Hypothyroid (underactive)	
Varicose veins		Burning while urinating		Hyperthyroid (overactive)	
NEUROLOGICAL / PSYCHIATRIC		Incontinence		Gout	
		FEMALE ONLY		Easily fatigued	
Nerve injury Specify:		Age menopause:		**OTHER**	
		Age first menstrual period:		Anemia	
Anxiety		Frequency of periods:		Cancer Type:	
Depression		Irregular menstrual cycles			
Panic attacks		Irregular bleeding / spotting		List:	
Dizziness		Frequent yeast infections			
Convulsions / seizures		# of pregnancies			
Anorexia / Bulimia		# of delivers			