CONFIDENTIAL MEDICAL HISTORY RECORD
CONCUSSION AND HEAD TRAUMA PROGRAM

Neurosurgical Associates of LVPG

A practice of Lehigh Valley Physician Group

Patient name (full): _____ Date: _____

Name of person completing form (if not the patient): _____

Birth date: _____ Height: _____ Weight: _____ Male __ Female __

DATE OF MOST RECENT CONCUSSION/HEAD INJURY: _____
DESCRIBE INJURY: _____
_____

SYMPTOMS IMMEDIATELY AFTER INJURY: _____
_____

DID YOU SEEK MEDICAL ATTENTION? YES____ NO____
WHERE DID YOU SEE MEDICAL ATTENTION?
_____

ANY TESTS PERFORMED? YES____ NO____
TESTS PERFORMED:
_____

LOCATION OF TESTS PERFORMED:
_____

DATE OF TESTS PERFORMED:
_____

DID YOU RETURN TO SPORTS? YES____ NO____ N/A____
IF SO, WHEN AND WHAT SPORT? _____

DID YOU RETURN TO SCHOOL? YES____ NO____ N/A____
IF SO, WHEN? _____
GRADE ATTENDING: _____ SCHOOL: _____

DID YOU RETURN TO WORK? YES____ NO____ N/A____
IF SO, WHEN? _____ TYPE OF WORK? _____

WHO REFERRED YOU TO THE CONCUSSION AND HEAD TRAUMA PROGRAM?
_____

Patient name_____ **DOB** _____ **MR#** _____

PAST HISTORY OF CONCUSSION/HEAD INJURY

DATE	DESCRIPTION OF INJURY	SYMPTOMS AND TREATMENT

CURRENT THERAPIES

	YES	NO	HOW OFTEN AND FACILITY
PHYSICAL THERAPY			
COGNITIVE THERAPY			
VESTIBULAR (BALANCE) THERAPY			
OCCUPATIONAL THERAPY			

LIST SPORTS YOU PLAY

SPORT	SEASON/MONTHS SPORT PLAYED INCLUDING PRACTICE

Patient name_____ **DOB** _____ **MR#** _____

CURRENT SYMPTOMS

THINKING/REMEMBERING	YES	NO
Difficulty thinking clearly		
Feeling slowed down/sluggish		
Difficulty focusing/concentrating		
Difficulty retaining information		
Memory loss		
Difficulty organizing daily tasks		
Difficulty making decisions		
Confusion		
Feeling groggy/foggy		
Difficulty following conversation		
Decline in academic performance		
PHYSICAL	**YES**	**NO**
Headache/ "pressure" in head		
"Fuzzy" or blurred vision		
Double vision		
Nausea/vomiting		
Dizziness		
Sensitivity to noise		
Sensitivity to light		
Decreased appetite		
Balance problems/unsteady on feet		
Feeling weak and tired		
EMOTIONAL/MOOD	**YES**	**NO**
Irritability		
Sadness/depressed		
Easier/quicker to anger or frustrate		
Nervous/anxious		
More emotional		

Patient name_____ **DOB** _____ **MR#** _____

CURRENT SYMPTOMS CONTINUED

SLEEP	YES	NO
Sleeping more than usual		
Sleeping less than usual		
Difficulty falling asleep		
Drowsiness		
Dreams/nightmares		

PAST MEDICAL HISTORY

Please check all that apply:

□__ Diabetes	□ __Seizures	□ __High blood pressure
□__ High cholesterol	□ __Hepatitis	□ __Heart disease
□__ Arthritis	□ __ Thyroid Disease	□ __Cancer _____
□__Migraines	□ __ Mental Disorder	□ __Blood clotting problems
□__ Tuberculosis	□ __HIV or Aids	□ __Kidney disease

□ Other: _____

FAMILY HISTORY

Condition	Who?	Condition	Who?
Heart Disease		Stroke	
Bleeding Problems		Cancer	
High Blood Pressure		Migraines	
Mental Disorder		Diabetes	
Other:			

Patient name_____ **DOB** _____ **MR#** _____

SURGICAL/PROCEDURE HISTORY

DATE	SURGERY/PROCEDURE	FACILITY/PROVIDER

CURRENT MEDICATIONS

Medication	Dose	How Often?	Reason for Taking

ALLERGIES: MEDICATION AND OTHER

Medication	Reaction

PHARMACY NAME: _____

PHARMACY PHONE: _____

PHARMACY ADDRESS: _____

Patient name_____ **DOB** _____ **MR#** _____

SOCIAL HISTORY

A. Family Situation – please check applicable

☐ __Married ☐ __Single ☐ __Widowed

☐ __Separated ☐ __Divorced ☐ Do you live alone? ☐ __Yes ☐ __No

B. Occupation

1. Are you currently employed? If so, what is your occupation?

_____

2. If retired, or not working, what was your occupation?

_____

C. Alcohol Use

1. Do you drink alcoholic beverages? ☐ __Yes ☐ __No
2. If yes, what is your daily, weekly, monthly or yearly use?

_____

D. Litigation

1. Do you have any litigation (lawsuit / lawyer) regarding your condition? __Yes ☐ __No
2. If yes, please describe: _____

E. Substance / Drug Use

1. Do you use any illegal drugs? (Marijuana, Ecstasy, Cocaine, etc.) ☐__Yes ☐ __No
2. If yes, please describe: _____

F. Tobacco Use

1. Do you use tobacco? ☐ __Yes ☐ __No
2. If yes, what type? __Cigarettes __Chewing Tobacco __Cigars ☐ __Other
   How often? How much? _____
   If you were a tobacco user in the past, what year did you quit? _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THESE FORMS.

_____

PATIENT NAME — PRINTED

_____

PATIENT SIGNATURE **DATE**

_____

PARENT/LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**