Banner Health

NEW PATIENT MEDICAL HISTORY - CONCUSSION / SPORTS MEDICINE

PATIENT NAME: _____ *Date of Birth:* _____/_____/_____

Gender Identity (Optional) _____

PARENT/GUARDIAN NAME: _____

**The following questions relate to your general health. The details of this form will only be reviewed by your health care provider. **

School: _____ Athletic Trainer: _____

Sport: _____

Referred for Evaluation by: _____

Preferred Pharmacy: (name and location) _____

CURRENT SYMPTOMS:

1. _____

2. _____

3. _____

CHRONIC MEDICAL PROBLEMS: ❑ None, healthy

❑ ADD/ADHD	❑ Headaches	❑ Hypertension	❑ Mood disorder
❑ Learning Disability	❑ Migraines	❑ Diabetes	❑ Other (list below)
❑ Depression	❑ Seizures	❑ Visual Problems	
❑ Anxiety	❑ Brain Injury	❑ Insomnia	

ALLERGIES: ❑ No Allergies

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

MEDICATIONS: ❑ No Medications

1. _____ Dosage: _____ # of Times a day _____

Reason for medication: _____

2. _____ Dosage: _____ # of Times a day _____

Reason for medication: _____

3. _____ Dosage: _____ # of Times a day _____

Reason for medication: _____

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NEW PATIENT MEDICAL HISTORY - CONCUSSION / SPORTS MEDICINE

PATIENT NAME: _____ *Date of Birth:* _____

MED/SURG/INTERIM History (Hospitalizations, ER visits, and Surgeries)

Hospital stays:

1. Reason: _____ Dates: _____
2. Reason: _____ Dates: _____

ER visits:

1. Reason: _____ Dates: _____
2. Reason: _____ Dates: _____

Surgeries:

1. Reason: _____ Dates: _____
2. Reason: _____ Dates: _____

DIAGNOSTIC TESTS:

CT head: _____/_____/_____ EMG: _____/_____/_____

EEG: _____/_____/_____ MRA/MRV: _____/_____/_____

MRI brain: _____/_____/_____ Other: _____

FAMILY MEDICAL HISTORY:

In particular any migraines, chronic headaches, ADD/ADHD, learning difficulties, depression, anxiety, mood disorder, seizures, Alzheimer's, dementia, Parkinson's, strokes in young (<55years old), developmental delays, multiple sclerosis, sudden unexplained deaths, and other illnesses that you know of?

Mother: _____

Father: _____

Siblings: _____

_____

OTHER: (grandparents/aunts/uncles/cousins):

_____

_____

SOCIAL HISTORY:

Alcohol use:	Y / N	Daily	Weekly	Monthly
Caffeine use:	Y / N	Daily	Weekly	Monthly
Illicit drug use:	Y / N	Daily	Weekly	Monthly

Who smokes in the family (including patient if patient smokes)? _____

Grade in school _____ Accommodation _____

Mother's occupation: _____

Father's occupation: _____

Any special spiritual/religious needs? _____

5100-0058
(01/2019)

Banner Health

NEW PATIENT MEDICAL HISTORY - CONCUSSION / SPORTS MEDICINE

PATIENT NAME: _____ *Date of Birth:* _____

HEAD INJURY SYMPTOMS:

Date of Injury: _____

How the injury occurred: _____

Describe injury: (hit to the head, to the body, twisting of the neck, etc.) _____

_____

Helmet use during injury: (circle please) Y / N

Location of injury (on body): (circle please)

Frontal Side: R / L Back Neck Face

Location of pain (circle please):

None Face Head Neck

Quality of the pain (circle please):

Aching Burning Dull Sharp Throbbing Stabbing

Constant Intermittent Other: _____

Risk factors (circle please):

Alcohol: Y/ N Recreational drugs: Y/ N Prescribed medications: Y/ N

Fractures (broken bones): Y /N If in car: seat belt: Y/ N

What make symptoms worse? (circle please)

Bending over Caffeine Exercise/Exertion Light Sound

Lying down Pressure Sitting up Smells Touch

Others? _____

What make symptoms better? (circle please)

Medications _____

Cold compresses Heat Rest Sleep Nothing

Others? _____

Associated symptoms: (circle please)

Bleeding from ears	Headache	Memory difficulty	Restlessness
Bruising around eyes	Hearing loss	Nausea	Seizures
Clumsiness	Incoordination	Smell disturbance	Sleepiness
Confusion	Increased thirst	Weakness	Speech change
Ear leakage	Irritable	Personality change	Stiff neck
Nose leakage	Consciousness loss	Increased need to pee	Behaviors
Bloody nose	Numbness	Projectile vomiting	Vision change
Fever	Lucidity		
Gait change	Homework time increased		

5100-0058
(01/2019)

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NEW PATIENT MEDICAL HISTORY - CONCUSSION / SPORTS MEDICINE

PATIENT NAME: _____ *Date of Birth:* _____

CONCUSSION HISTORY:

Have you ever been diagnosed with a head injury or concussion in the past? ❑ No ❑ Yes
(Please list the details below)

	Year/Symptoms	Duration	Imaging (CT, MRI, X-ray)	Treatment
1.				
2.				
3.				

Do you get car sick? ❑ No ❑ Yes ❑ Sometimes

DIZZINESS:

Are you experiencing any symptoms of vertigo (spinning sensation)? ❑ No ❑ Yes
If yes, how long does the spinning last? ❑ Less than 1 minute ❑ 2-5 minutes ❑ 5 or more minutes
Are you experiencing symptoms of dizziness (fogginess and/or difficulty focusing)? ❑ No ❑ Yes
Are you feeling off balance? ❑ No ❑ Yes

VISION:

Do your eyes feel tired when reading or doing close work? ❑ No ❑ Yes
Do you notice the work blurring or coming in and out of focus when reading or doing close work? ❑ No ❑ Yes
Do you have blurred vision at far distance? ❑ No ❑ Yes
Do you cover or close one eye to see well? ❑ No ❑ Yes

5100-0058
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