NORTHSIDE HOSPITAL
CONCUSSION INSTITUTE

PATIENT HISTORY FORM (Adult)
Concussion Institute

PATIENT DEMOGRAPHICS

Patient Name: _____ **DOB:** _____ **Sex:** ☐Male ☐Female

Address: _____

Home Phone: _____ **Cell:** _____ **Email:** _____

What is your preferred contact method? ☐Home phone ☐Cell phone ☐Email

Who referred you to us? _____

Do you need an interpreter? ☐No ☐Yes: **Language?** _____

Preferred Pharmacy: _____ **Pharmacy Phone:** _____

Emergency Contact: _____ **Emergency Phone:** _____

What is the reason for your visit? _____

PAST MEDICAL HISTORY

Please select any condition(s) that you have previously been treated for:

☐ High Blood Pressure
☐ Heart Attack
☐ Heart Arrhythmia
☐ Heart Disease
☐ High Cholesterol
☐ Varicose Veins
☐ Fainting
☐ Cancer
☐ Seasonal Allergies
☐ Motion Sensitivity
☐ Asthma
☐ COPD or Emphysema
☐ Pneumonia
☐ Tuberculosis
☐ Osteoarthritis
☐ Bursitis
☐ Gout
☐ Ankylosing Spondylosis
☐ Reiter Syndrome
☐ Indigestion
☐ Heart Burn
☐ Stomach Ulcers
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Psoraisis
☐ Diabetes
☐ Hepatitis
☐ Thyroid Disease
☐ Anemia
☐ Steroid Use
☐ Liver Disease
☐ Blood Disorder

Psychiatric:
☐ Anxiety
☐ Depression
☐ Mood Problems
☐ Cutting or Self-Harm
☐ ADD or ADHD
☐ Learning Disability

Neurologic:
☐ Headaches
☐ Migraines
☐ Dizziness
☐ Motion Sickness
☐ Alzheimer's Disease
☐ Dementia
☐ Seizure or Epilepsy
☐ Stroke
☐ Paralysis
☐ Multiple Sclerosis
☐ Speech Problems

Provide details to any conditions you selected:

_____

Previous surgeries: _____

_____

Allergies: _____ ☐ No Known Allergies

MEDICATIONS

Please list ALL current prescriptions or over-the-counter medicines that you currently take: ☐No Current Medications

Medication Name	Dosage	How Often?	Reason

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REVIEW OF SYSTEMS

Please select any symptoms you have experienced in the LAST TWO WEEKS:

Constitutional:
☐ Appetite Change
☐ Weight Change
☐ Fever
☐ Fatigue
☐ Chills
☐ Malaise

Neurological:
☐ Headaches
☐ Migraines
☐ Seizure
☐ Stroke
☐ Paralysis
☐ Speech Problems

Eyes, Ear, Nose, Throat:
☐ Vision Changes
☐ Dizziness
☐ Hearing Changes
☐ Ringing in Ears
☐ Nose Bleeds
☐ Sore Throat

Gastrointestinal:
☐ Indigestion
☐ Heart Burn
☐ Stomach Problems
☐ Diarrhea
☐ Constipation
☐ Blood in Stool

Psychiatric:
☐ Anxiety
☐ Depression
☐ Stress
☐ Mood Problems
☐ Cutting or Self-Harm

Cardiovascular:
☐ Chest Pain
☐ Varicose Veins
☐ Fainting
☐ Edema
☐ Swollen Ankles

Musculoskeletal:
☐ Arthritis
☐ Bursitis
☐ Gout
☐ Weakness
☐ Numbness

Genitourinary:
☐ Painful Urination
☐ Blood in Urine
☐ Difficulties Urinating
☐ Loss of Control
☐ Erection Problems

Hemilyphmatic:
☐ Anemia
☐ Easily Bruise
☐ Lymph Node Swelling

Respiratory:
☐ Shortness of Breath
☐ Coughing
☐ Wheezing

Skin:
☐ Itching
☐ Rashes
☐ Hives

Endocrine:
☐ Breast Lump/Discharge
☐ Frequent Thirst/Urination
☐ Steroid Use

SOCIAL, SPIRITUAL & CULUTURAL

Is the patient employed? ☐Yes ☐No **If so, where?** _____ **# Hours per week:** _____

Job Responsibilities: _____

Is the patient in school? ☐Yes ☐No **If so, where?** _____ **# Hours per week:** _____

Do you have any religious, spiritual, or cultural beliefs that may affect your care? ☐No ☐Yes

Do you feel that you have been abused, neglected, or exploited by someone close to you? ☐No ☐Yes

Do you drink alcohol? ☐No ☐Yes **Do you use tobacco?** ☐No ☐Yes **Do you use other drugs?** ☐No ☐Yes

Explain any "Yes" answers: _____

_____

FAMILY HISTORY

Please list everyone (age & relationship) with whom the patient lives with:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list any medical conditions within your biological family:

_____

_____

_____