St.Charles Orthopedics
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Today's Date: ____________

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Confidential Medical History
Concussion: Follow-Up Visit Form

Patient Name: _________________________ Date of Birth:_____________ Date of Injury: ____________

1) Is there a new problem that was not evaluated at your last visit? [ ] Y [ ] N If so, what is it? __________________

2) Since your last visit, are you: [ ] Better [ ] Worse [ ] Same

3) On a scale of 0-100% how much better are you now?_____________ If NO better put 0%.

4) Medications: Were you prescribed any medications at your last visit? [ ] Y [ ] N Meds:_______________
Has another physician prescribed you **NEW** medications? [ ] Y [ ] N Meds:_______________
What are you still taking (include over the counter meds)? [ ] None Meds:_______________
If you are taking medications:
Did you experience any side effects? [ ] Y [ ] N If so, what?______________________
Did the medication help? [ ] Y [ ] N If so, how? ______________________

5) Use the check boxes below to show what other treatments were done at or since your last visit:

Treatment	*Did it Help?*	*Treatment*	*Did it Help?*
[ ] Physical/Vestibular Therapy	[ ] Y [ ] N	[ ] Visual Therapy	[ ] Y [ ] N
[ ] Psychology	[ ] Y [ ] N	[ ] Other_________________	[ ] Y [ ] N
[ ] Neuropsychology	[ ] Y [ ] N	[ ] **None of the above**	

6) Circle your current symptoms: NONE

Headache	Numbness/Tingling	Irritability	Sleeping More
Nausea	Vomiting	Depression	Sleeping Less
Fatigue	Dizziness	Sadness	Trouble Falling Asleep
Visual Problems	Feeling Mentally Foggy	Feeling More	
Balance Problems	Problems Concentrating	Emotional	
Sensitivity to Light	Problems Remembering	Nervousness	
Sensitivity to Noise	Feeling Slowed Down	Drowsiness	

7) Has anything made your symptoms worse? [ ] Y [ ] N If so, please describe: ____________________________

8) If symptom free, how many days have you been free of symptoms? [ ] N/A [ ] __________ days

9) Have you started the return to play progression? [ ] Y [ ] N If so, what step are you on? _______________

10) Since your last visit have you developed new problems in any of the following areas: **[ ] NONE**

[ ]Eyes	[ ] Y [ ] N	[ ]Skin	[ ] Y [ ] N	[ ]Lungs	[ ] Y [ ] N	[ ]Nerves	[ ] Y [ ] N
[ ]Heart	[ ] Y [ ] N	[ ]Joints	[ ] Y [ ] N	[ ]Urine	[ ] Y [ ] N		
[ ]Bowels	[ ] Y [ ] N	[ ]Ears	[ ] Y [ ] N	[ ]Diabetes	[ ] Y [ ] N		

Please Describe:____

11) Current job status: [ ] Do not work [ ] Regular job [ ] Light duty [ ] Not working due to current condition

12) Current school status(if applicable): [ ] Full time [ ] Half days [ ] No tests [ ] Limited homework
[ ] Have you needed rest breaks during the day?

13) If you are an athlete, when is your next scheduled game? ______________What sport? ____________________