ORTHOPEDIC ASSOCIATES OF LONG ISLAND
PRECISIONCARE

ThinkSMART!
Concussion Management Program

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Confidential Medical History
Concussion Follow Up

Name: _____ Date of Birth: _____ Date of Injury: _____

Are there any new problems that were not evaluated at your last visit? Yes No If so, what? _____

On a scale of 0-100%, how much better are you now? _____ (If there is no improvement, please put 0%)

Were you prescribed any medication at your last visit? Yes No Meds: _____

Has another physician prescribed you **NEW** medications? Yes No Meds: _____

What medications are you **currently** taking (include over-the-counter meds)? _____

If you are taking medication:

Have you experienced any side affects? Yes No Describe: _____

Has the medication helped? Yes No Describe: _____

Use the check boxes below to show what other treatments were done since your last visit (circle 'yes' or 'no'):

Treatment	Did it help?		Treatment	Did it help?	
Physical/vestibular therapy	Yes	No	Visual Therapy	Yes	No
Psychology	Yes	No	Other _____	Yes	No
Neuropsychology	Yes	No	None of the above	Yes	No

Circle your **current** symptoms:

Headache	Vomiting	Sadness
Nausea	Dizziness	Feeling more emotional
Fatigue	Feeling mentally foggy	Nervousness
Visual problems	Problems concentrating	Drowsiness
Balance problems	Problems remembering	Sleeping more
Sensitivity to light	Feeling slowed down	Sleeping less
Sensitivity to noise	Irritability	Trouble falling asleep
Numbness/Tingling	Depression	

Has anything made your symptoms worse? Yes No Describe: _____

If you are symptom free, how many days has this been the case (or write 'not applicable.')? _____

Have you begun the Return to Play progression? Yes No If 'yes,' what step are you on? _____

Current Job Status (circle one): Do not work Regular duty Light duty Not working due to current condition

Current school status (if applicable – circle all that apply): Full time Half days

No tests Limited homework

Have you needed breaks during the day? Yes No

If you are an athlete, when is your next scheduled game? _____ What sport? _____

Patient Name: _____ Date of Birth: _____

Review of Systems

Check any symptom below that you are currently experiencing or have experienced in the past weeks:

Abdominal pain	□ Yes	□ No	Glasses	□ Yes	□ No
Anxiety	□ Yes	□ No	Headache	□ Yes	□ No
Balance problem	□ Yes	□ No	Hearing loss	□ Yes	□ No
Blood in urine	□ Yes	□ No	Hot flashes	□ Yes	□ No
Blurry vision	□ Yes	□ No	Immune system issue	□ Yes	□ No
Bowel incontinence	□ Yes	□ No	Insomnia	□ Yes	□ No
Cellulitis (infection)	□ Yes	□ No	Irregular heartbeat	□ Yes	□ No
Chest pain	□ Yes	□ No	Joint pain	□ Yes	□ No
Cold intolerance	□ Yes	□ No	Joint stiffness	□ Yes	□ No
Constipation	□ Yes	□ No	Muscle aches	□ Yes	□ No
Contacts	□ Yes	□ No	Nose bleeds	□ Yes	□ No
Coordination problem	□ Yes	□ No	Pain with urination	□ Yes	□ No
Cough	□ Yes	□ No	Rash	□ Yes	□ No
Depression	□ Yes	□ No	Ringing in ears	□ Yes	□ No
Diarrhea	□ Yes	□ No	Seasonal allergies	□ Yes	□ No
Double vision	□ Yes	□ No	Seizure	□ Yes	□ No
Easy bleeding	□ Yes	□ No	Shortness of breath	□ Yes	□ No
Easy bruising	□ Yes	□ No	Sore throat	□ Yes	□ No
Eating disorder	□ Yes	□ No	Urinary incontinence	□ Yes	□ No
Excessive thirst	□ Yes	□ No	Weight gain	□ Yes	□ No
Fatigue	□ Yes	□ No	Weight loss	□ Yes	□ No
Fever/chills	□ Yes	□ No	Wheezing	□ Yes	□ No

What goals do you have for today's visit? _____

_____

Would you like today's note to be sent to another physician? □ Yes □ No

If yes, please complete a Medical Release form and provide your doctor's information.
The Medical Release form can be found at the front desk.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____