ORTHOPEDIC ASSOCIATES OF LONG ISLAND
PRECISIONCARE

ThinkSMART!
Concussion Management Program

Dr. Danielle DeGiorgio, DO

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:

Symptom			Symptom		
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? ____

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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: ____________________