

UPMC Sports Medicine

UPMC Concussion Program

General Information

Name _____ DOB _____

Height _____ ft _____ in Weight _____

School/ Organization _____

Handedness: R or L or Both Gender: Male or Female

Language

Native Country _____

Native Language _____

Education

Years of Education Completed (excluding kindergarten; e.g., high school senior is 11 years)
_____ years

Check any of the following that apply:

- Received speech therapy
- Attended special education classes
- Repeated one or more years of school
- Diagnosed attention deficit disorder or hyperactivity
- Diagnosed learning disability

While in school, what type of student are/were you? (circle one)

Below Average Average Above average

Sports

Current Sport/Activity: _____

Position/ event/ class _____

Level of participation _____

(e.g.: youth, middle school, high school, semi-professional, collegiate etc)

Years of experience at this level: _____

(Approximate if needed; e.g., high school senior is 3 years)

Concussion
History

Number of times diagnosed with a concussion: _____

Total number of concussions that have resulted in loss of consciousness

Total number of concussions that resulted in confusion.

Total number of concussions that resulted in difficulty with memory of events occurring immediately **AFTER** injury.

Total number of concussions that resulted in difficulty with memory of events occurring immediately **BEFORE** injury.

Total number of games that were missed as a result of concussions.

Please List your five most recent concussions: _____
(use approximate dates if needed)

Indicate whether you have experienced the following:

- Yes No Treatment for headaches by physician
Yes No Treatment for migraine headaches by physician
Yes No Treatment for epilepsy/ seizures
Yes No History of brain surgery
Yes No History of meningitis
Yes No Treatment for substance/ alcohol abuse
Yes No Treatment for psychiatric condition (depression, anxiety etc.)

Have you ever been diagnosed with the following?

- Yes No ADD/ADHD
Yes No Dyslexia
Yes No Autism
Yes No Have you participated in strenuous exercise in the last 3 hours?

Total hours of sleep last night: _____hours

Current medications: _____
