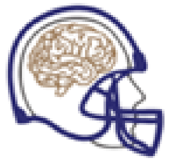
Robert C. Cantu Concussion Center
Emerson Hospital



Reevaluation Form

Reason for visit: ____

Is this a new head injury? Yes No

If yes, date of new injury: ______________ How was the injury sustained? ______________________

Any changes to your medical history? (e.g. high blood pressure, surgeries, hospitalizations): Yes No

If yes, please describe: ____

Allergies: Yes No If yes, please list: ______________________________

Please list all current medications: ______________________________________

____

Current Height: __________________ Weight: _________________

Any changes to social history? (e.g. employment, relationship status): Yes No

If yes, please describe: ____

Are you involved in a legal case? Yes No If yes, who is your attorney? ______________________

Any falls within the past 6 months? Yes No If yes, when? ______________________________

Are you being hurt or made to feel afraid? Yes No

Do you have any thoughts of self-harm or dying? Yes No

Any changes to family history? Yes No If yes, please describe ______________________

____

Are you experiencing any of the following? Please ✓ all that apply.

☐ Fever	☐ Neck swelling	☐ Skeletal deformities	☐ Blind spots
☐ Night sweats	☐ Limited neck movement	☐ Muscle/joint pain	☐ Hearing impairment
☐ Poor appetite	☐ Wheezing	☐ Back pain	☐ Vision impairment
☐ Change in weight	☐ Abdominal pain	☐ Difficulty walking	☐ Flashing lights
☐ Disorientation	☐ Bowel/bladder problems	☐ Imbalance	☐ Migraine headaches
☐ Runny nose	☐ Constipation	☐ Face weakness	☐ Trouble swallowing
☐ Sore throat	☐ Diarrhea	☐ Moles	☐ Trouble talking
☐ Dental problems	☐ Reflux/heartburn	☐ Itching	☐ Other:
☐ Chest pain	☐ Pain with urination	☐ Growth problems	
☐ Shortness of breath	☐ Blood in urine	☐ Temperature irregulation	
☐ Cough	☐ Frequent/urgent urination	☐ Thyroid problems	
☐ Heart murmur	☐ Unusual urine odor	☐ Abnormal bleeding	
☐ Palpitations/Irregular heartbeat	☐ Menstrual irregularities	☐ Lymph node swelling	

______________________________ ______________ ______________

Signature of Patient or Patient's Legal Representative Date Time

______________________________ ______________________________

Print Name Legal Representative (if applicable) Relation to Patient