

**CONCUSSION QUESTIONNAIRE
 TO BE COMPLETED BY PHYSICIAN**

Player's Name:

Age:

How many concussions has the player suffered? Please give dates of concussions.	
Indicate grade of concussions	
Did the player suffer any loss of consciousness? If so, for how long (please include vital signs).	
Detail the player's condition at time of incident:	
Was the player hospitalized? If so, for how long.	
Did you prescribe any medication? If so, what was the name of the drug, the dosage and frequency.	
Was a CAT scan performed (if yes what were the results)	
What was the player's condition upon release?	
What was the length of recovery prior to participating in the next game?	

Please indicate symptoms suffered **immediately following concussion**

Headaches	Yes	No	Loss of Memory	Yes	No
Blurred Vision	Yes	No	Ringing in Ears	Yes	No
Fatigue	Yes	No	Cognitive Changes	Yes	No
			Language Difficulty	Yes	No

Other (please explain)

After the player was cleared to play, did he suffer any of the following symptoms:

Headaches	Yes	No	Loss of Memory	Yes	No
Blurred Vision	Yes	No	Ringing in Ears	Yes	No
Fatigue	Yes	No	Cognitive Changes	Yes	No
			Language Difficulty	Yes	No

Other (please explain)

Physicians Signature

Date