Please complete the attach Follow-Up Forms and return to the TBI Clinic upon the arrival of your appointment. If the forms are not received, we will reschedule your appointment at that time.
FOLLOW-UP FORM: WARRIOR CARE CLINIC

Your Visit Today is With:  □ Dr. Asobo  □ Dr. Sebesta  □ Ms. Chavez, NP

PLEASE ANSWER EVERYTHING ON PAGES 1 & 2  CIRCLE  or ✓ CHECK WHERE APPROPRIATE

DATE: ___________________ NAME: ___________________ PHONE: ( ) ___________________

RANK: _______ UNIT: _______ DOB: _______ SSN: ___________________

Are you in the WTB?  □ YES  □ NO  If yes, Nurse Case Manager’s name & phone: ___________________

Are you in a Medical Board or think you will be in one within the next 6 months?  □ YES  □ NO

WHERE DO YOU WANT TO PICK UP YOUR MEDS?  □ BIGGS  □ PX  □ SFMC (FT BLISS)  □ WBAMC

MEDICATION ALLERGIES?  □ YES/□ NO  If YES, LIST: ___________________

Are you allergic to latex?  Yes/No

LIST CURRENT MEDICATIONS (Circle those that need a refill.): (If none, check here□) ___________________

YOUR PAST MEDICAL HISTORY: (If none, check here□)  □ PTSD  □ DEPRESSION  □ ANXIETY

□ HIGH BLOOD PRESSURE  □ ASTHMA  □ HEADACHE  □ Alcoholism/Abuse  □ Drug Abuse

□ Attention-Deficit Hyperactivity  □ Learning Disability  □ Special Education  □ ANY OTHERS:

LIST ANY OTHERS:

YOUR SURGICAL HISTORY: (If none, check here□) ___________________

FAMILY MEDICAL HISTORY (LIST BY MOTHER/FATHER/SISTER/BROTHER). Be sure to include any mental illness, alcoholism, heart disease, cancer, or diabetes. (If none, check here□)

ARE YOU CURRENTLY HAVING: 1) Suicidal thoughts?  □ YES  □ NO  2) Homicidal thoughts?  □ YES  □ NO

DOMESTIC VIOLENCE IN YOUR HOME?  □ YES  □ NO  ARE YOU DEPRESSED?  □ YES  □ NO


TOBACCO USE?  □ YES  □ NO  IF YES: WHAT TYPE? ________________  QUANTITY: ________________  Do You want to quit? Yes/No

LEVEL OF PAIN AT THIS MOMENT:  0  1  2  3  4  5  6  7  8  9  10  WHERE? ________________

HAVE YOU HAD A HEAD INJURY/CONCUSSION SINCE YOUR LAST VISIT?  □ YES  □ NO  IF YES: __________________

__________________________________________________________

__________________________________________________________
HEADACHES

HISTORY
DO YOU HAVE MODERATE OR SEVERE HEADACHES? □ YES  □ NO (If no, skip to next page.)
DID YOUR HEADACHES START WITH A CONCUSSION OR HEAD INJURY? □ YES  □ NO
ARE YOU SATISFIED WITH THE CONTROL OF YOUR HEADACHES AT THIS TIME? □ YES  □ NO

DESCRIPTION (Circle or check)
WHO HAS BEEN TREATING YOU FOR THESE HEADACHES? □ TBI Program □ Neurology
□ Primary Care Provider □ Other______________________________

DID WE CHANGE YOUR HEADACHE MEDICATIONS AT LAST VISIT? □ Yes □ No

The Number of Severe Headaches I have per week or month has: □ Stayed the Same
□ Decreased □ Increased How many severe headaches do you have per week ______ or per month?________

The severity of my Severe Headaches has: □ Stayed the Same □ Decreased □ Increased

Did your Headache Medication Give You Any Side Effects? □ Yes □ No

If "Yes," what side effects did you have?________________________________________
**CHECK EACH ITEM THAT APPLIES TO YOU.**

<table>
<thead>
<tr>
<th>Item</th>
<th>☐ YES</th>
<th>☐ NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Concentration</td>
<td></td>
<td></td>
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<tr>
<td>Irritable</td>
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<tr>
<td>Tired All the Time</td>
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<tr>
<td>Memory Problems</td>
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<tr>
<td>Anxiety/Worry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble Thinking/Understanding</td>
<td>☐ YES</td>
<td>☐ NO</td>
</tr>
</tbody>
</table>

**Dizziness/Balance Issues:** ☐ YES ☐ NO (ONLY WITH HEADACHES? ☐ YES ☐ NO)

**Blurry Vision:** ☐ YES ☐ NO  **Double Vision:** ☐ YES ☐ NO

If you get headaches, do you have blurry/double vision ONLY WITH HEADACHES? ☐ YES ☐ NO

**Sensitivity to Bright Light:** ☐ WITH HEADACHES ONLY ☐ EVEN WITHOUT HEADACHES

**Do you have difficulty sleeping?** ☐ YES ☐ NO

If so, about how many hours total of actual sleep per night? ___________

**Nightmares?** ☐ YES ☐ NO

**Active Sleep?** ☐ YES ☐ NO If yes, do you: ☐ Yell/Scream ☐ Punch/Kick ☐ Sleep Walk.
FOR STAFF ONLY.
HT: __ WT: ___ BMI: ___ BP ___/___ HR ___ RR ___ TEMP ___ O2% SAT ___

RESPECT-MIL POSITIVE SCREEN: □ PTSD □ DEPRESSION

REQUIRED INFORMATION AT DISCHARGE—Give to Ms. Calderon

Total # of Psychotropic Medications | Total # of Medications
-------------------------------------|-------------------------

(Do not include sleep medications in # of Psychotropic Medications)

<table>
<thead>
<tr>
<th>SM is PCSing or ETSing</th>
<th>D/C from TBI PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>SM is was/is in MEB &amp; Discharged from Army</td>
<td>Soldier is FFD from TBI perspective? Yes No</td>
</tr>
</tbody>
</table>

FUNCTIONAL STATUS at Discharge: 1 2 3 4 5 6 7

CONSULTS: □ SP □ OT □ PT □ AUDIOLOGY □ OPTOMETRY □ NEUROPSYCH □ IN-HOUSE BH
□ OUTPATIENT BH □ MENTIS □ NEUROLOGY □ MRI □ LABS __________

OTHER CONSULTS: __________

MEDICATIONS: □ BIGGS □ SFMC □ WBAMC □ PX □ MEDS NEEDED __________

FOLLOW-UP: 1 2 3 4 5 6 7 8 9 10 11 12 □ DAYS □ WEEKS □ MONTHS
( □ TBI □ PTSD □ JUMPSTART CANDIDATE □ D/C from TBI PROGRAM)

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