NEW HEADACHE PATIENT HISTORY

DATE: _________________

To the patient:
Your history is typically the most valuable contribution to diagnosis and subsequent treatment. If you have any questions regarding the form, please ask.

A. Identification

Name:
Age:
Sex:
DOB (month/day/year): _________

B. Headache History

At what age did you first begin to experience a significant problem w/ recurrent or persistent headache?
Put another way, how old were you when you first began to have headaches bad enough to interfere with your normal daily activities? ______ (don't know___)

Have you experienced any recent change in the character or frequency of your headaches?
___no ___ yes (if yes, what kind of change:
____
____
____}

How long do your worst headaches last?
a) 0-1 hrs ___ b) >1-3 hrs ___ c) 4-12 hrs __ d) 12-24 hrs __
e) 24-48 hrs ___ f) 48-72 hrs ___ g) > 72 hrs __ h) unknown __

In the last 30 days, how many days were you headache-free or nearly so? ___

Over the last 30 days, on how many days did you a) have a headache of any severity (mild, moderate or severe) that lasted at least 4 hrs, or
b) take a medication (prescription or over-the-counter) for a headache of any duration? ___

Are your headaches ever incapacitating (that is, cause you to be entirely unable to carry out your

usual daily activities for at least 1 hour)? ___no ___ yes

If yes, on how many of the last 30 days were you incapacitated by headache for at least 1 hour? ____

With your most severe headaches, does physical activity worsen the pain? ___ no ___ yes

Is your headache pain ever throbbing? ___ no ___yes

Is your headache ever localized to one side of the head? ___ no ___ yes
If yes, headache always on the same side? ___ no ___ yes
If yes, which side? ___ right ___ left

Does your headache ever arise from your neck or the base of your skull? ____no ___ yes (if yes, out of 10 severe headaches, how many arise from that location? ____)

Check any headache-associated symptoms you experience:
____ eye tearing
____ nasal congestion/runny nose
____ nausea
____ vomiting
____photophobia
____ sonophobia
____"aura" (examples: visual blind spots, flashes, or zig-zags; numbness/tingling in face or hand)

C. Medical and Surgical History

Do you have (or have you ever had)…
_____ hypertension
_____ heart disease (describe:____)
_____ diabetes
_____ significant head injury (if yes, within the past 6 months? _____ no _____yes)
Describe any significant head injury (When? Any loss of consciousness? Evaluated in an ER? Hospitalized?
____

____

_____ kidney stones
_____ sleep apnea
_____ treated for depression, past or present (with counseling, medication, or both)
_____ generalized anxiety disorder
_____ panic disorder
_____ active cigarette smoking (# of cigarettes per day _____)
_____ drug allergies (please list: ____)

List what surgeries you've had, including approximate dates:

____

____

Other significant medical conditions or psychiatric problems not listed above:

____

____

Current preventive Rx for headache? ___no ___ yes (name(s) and dose(s), if known):

____

What medications, prescription or over-the-counter, do you currently take when you have a headache?

____

None ___

If you are female, are you of child-bearing potential?
__ NA ___no __ yes (if yes, are you practicing adequate contraception? ___no __yes (what

method? ____)

Have you ever had a brain imaging study in the past? ___no ___yes ___unknown
If yes, what type?
___ CT
___ MRI
___ both
___ unknown

Where and when was the most recent scan preformed?

____

D. Family History

Do you have a1st degree relative who has migraine (mother, father, sister, brother, son, daughter)? ___no ___ yes ___ unknown
Who?

____

E. Review of Systems

Do you have chronically disrupted sleep?___ no___ yes (describe:____________________

____)

Are you actively depressed? ___ no ___ yes (if yes, is your depression ___mild ___moderate ___severe

Arctively receiving treatment for depression, anxiety or another psychiatric disorder? ___no __ yes

Are you chronically anxious? ___no ___ yes

G. Medication History

Headache Preventative Medications, Past or Present

Drug name	***Why stopped? (put checkmark if still taking the drug)***	***Maximum dose achieved***	***How long did you take it?***	***Effective?***	***Side effects, if any***
topiramate/short-acting (eg, Topamax)					
topiramate/long-acting (eg, Trokendi)					
amitriptyline (eg, Elavail)					
nortriptyline (eg, Pamelor)					
propranolol (eg, Inderal)					
occipital nerve blocks			How many treatments?		
Botox injections			How many treatments?		
Aimovig					

Emgality					
Ajovy					
Other (eg, divalproex sodium/Depakote)					

Medications for Treatment of Acute Headache, Past or Present

Drug name	***Don't know/can't remember***	***Why stopped? (put checkmark if still using it)***	***Did/does it help you?***	***Side effects, if any***
sumatriptan-oral (eg, Imitrex)				
sumatriptan-injectable (egs, Imitrex, Zembrace)				
sumatriptan-intranasal (eg, Tosymra)				
rizatriptan (eg, Maxalt)				
zolmitriptan-oral (eg, Zomig)				
zolmitriptan-intranasal				
eletriptan (eg, Relpax)				
almotriptan (eg, Axert)				
frovatriptan (eg, Frova)				
naratriptan				

(eg, Amerge)				
Treximet				
naproxen sodium (eg, Aleve)				
indomethacin (eg, Indocin)				
oral steroid (eg, prednisone)				
DHE nasal spray (eg, Migranal)				
Ubrelvy				
Nurtec				
Reyvow				
Other				