Consultants In Neurology, S.C.

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HEADACHE

Today's Date

Last Name First MI

Date of Birth Age

GENERAL PATIENT INFORMATION

You must complete or already have on file the ***patient medical history short form*** or ***long form***.
Please make sure that all of the information on your medical history form is updated including phone numbers, addresses and insurance information.
Answer the following questions and bring the answers to your appointment.

PRESENT ILLNESS - HEADACHES

My headaches first started on or about:

I get headaches about every: day week month 3 months year

My headaches last: seconds minutes hours days

Describe the head pain you experience: (check all that apply)

Throbbing	Pulsating	Pounding	Constant
Tight	Squeezing	Pressure	Sharp
Grinding	Vise-like	Hat-band	Tender
Other:			

Check the numbers that represent the **minimum, maximum** and **average** severity of your pain:

Mild 1 2 3 4 5 6 7 8 9 10 Severe

When do you usually get headaches? Morning Afternoon Night There is no pattern

Are your headaches worse with changes in position (prone, sitting, standing etc.)? Yes No

Are your headaches associated with:

Menstrual cycle Allergy/sinus problems Cold/flu Changes in weather

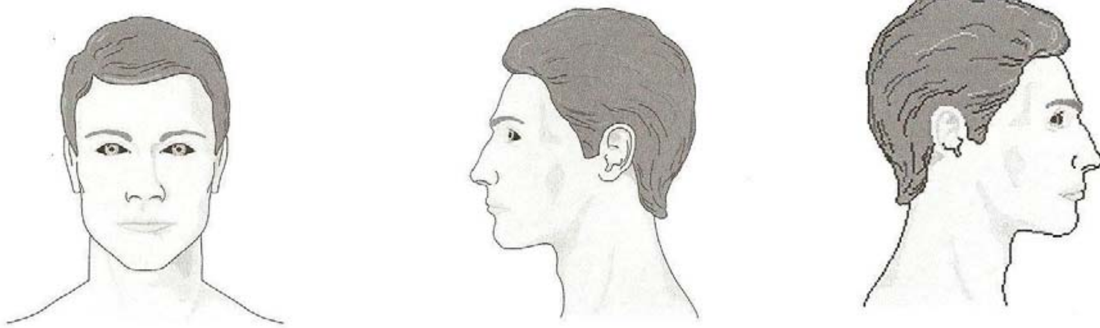
Do your headaches waken you in the middle of the night? Yes No

Do you ever waken with your jaws clenched together? Yes No

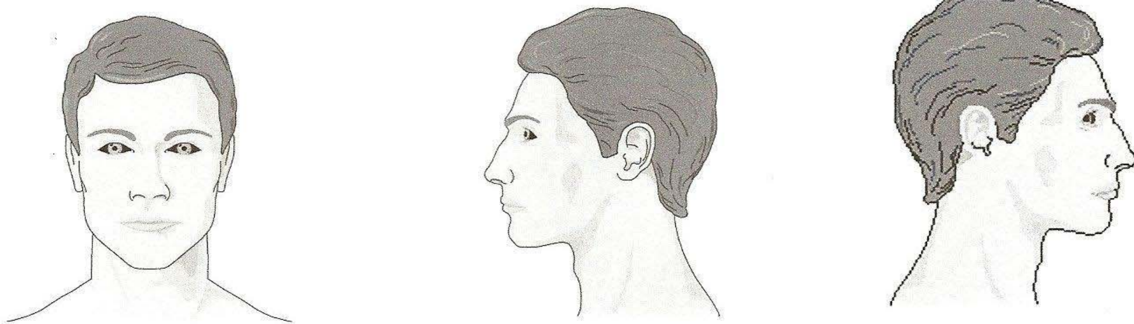
Do you wake up in the morning with headaches? Yes No

Do you snore? Yes No

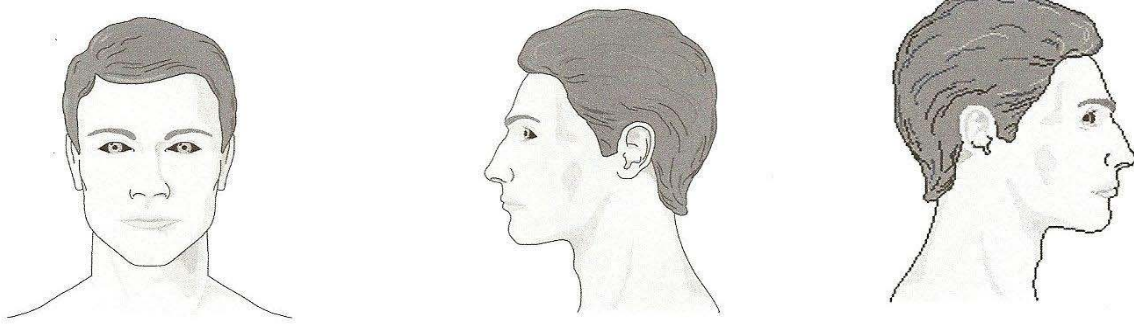
My headaches are located: (mark location, one or several)



My headaches start here: (if applicable check area headaches tend to start)



My headaches end here: (if applicable check where headaches end)



MY HEADACHE IS ACCOMPANIED BY: (check all that apply)

Diarrhea	Dizziness	Drooping eye lid
Facial tenderness	Fever	Flushing on the face
Light sensitivity	Loss of consciousness	Nausea or vomiting
Neck stiffness	Noise sensitivity	Numbness in face/arm/leg
Red, tearing eye	Runny nose/congestion	Swelling of ankles
Speech disturbance	Weakness in face/arm/leg	Abdominal pain
Neck pain	Neck tightness	Jaw pain or jaw clenching

Visual disturbances

Black spots	Heat waves
Flashing lights	Jagged lines
Other:	

MY HEADACHE IS TRIGGERED BY THE FOLLOWING? (check all that apply)

Alcoholic beverages	Seasons
Bending over	Swallowing
Blood Pressure	Sleep or lack of sleep
Bright Lights	Time of day
Colds	Sex
Coughing	Salt
Depression, anxiety, nerves, or stress	Exertion, exercise
Fatigue	Foods (such as cheese or chocolate)
Heat, hot showers	Head movement
Loud noises	Menstrual periods
Meals, or missing meals	Monosodium glutamate (MSG)
Odors	Other:

MY HEAD PAIN IS RELIEVED BY: (check all that apply)

Cold compresses	Eating	Heat	Massage
Moving around	Relaxation	Sleep	Vomiting

Medication (which ones?)

Other:

LIFE STYLE - HABITS

How many alcoholic drinks per week? None

Do you smoke cigarettes, cigars or pipes? No Yes

How many caffeinated drinks per day? None More than 4

Do you have regular sleep/wake patterns? No Yes

Do you salt your food? No Moderate Lots

Are you involved in a lawsuit with respect to any medical problems? No Yes

Are you usually highly stressed? No Yes

Do you usually eat 3 meals/day? No Yes

INJURIES (Check and date)

Head date

Neck (for example whiplash) date

Dental work preceding onset of headache date

EXPOSURES OR INFECTIONS: (Check and date)

Carbon Monoxide (car or house) date

Tuberculosis or Cysticercosis date

History of meningitis date

MEDICATIONS

What are your current medications, include hormones, birth control pills, vitamins, etc. (Name and amount/day)?

Medication	Amount	Medication	Amount
1		6	
2		7	
3		8	
4		9	
5		10	

Have you ever taken any of the following medicines for headache: (check)

Alleve	Amerge	Amitriptyline	Anacin	Antihistamines		Aspirin
Axert	Axotal	Bellergal	Botox	Bufferin		Cafergot
Calan	Codeine	Cyproheptadine		Darvon/Darvocet		Datril
Dapro	Depakote	Dilantin	Decongestants		Demerol	Depakote
DHE	Duradrin	Effexor	Empirin	Elavil	Ergomar	Ergostat
Esgic	Fentanyl patch		Feverfew	Fiorinal	Gabatril	Ibuprofen
Imitrex (or related drug)		Inderal	Indocin	Indomethacin	Lithium	Magnesium
Methadone	Maxalt	Midrin	Motrin	Naprosyn	Norflex	Norgesic
Nortriptyline	Nuprin	Oxygen	Paxil	Pamelor	Percodan	Percogesic
Periactin	Phrenilin	Relpax	Robaxin	Sansert	Sertraline	Sinutab
Soma	Stadol Nasal Spray		Sumatriptin	Topamax	Tylenol	Venlafaxine
Verapamil	Vivactyl	Vicodin	Wellbutrin	Zoloft	Zomig	
Other:						

PAST MEDICAL HISTORY, REVIEW OF SYSTEMS

My health has been affected by: (check, date)

General Health Problems

Heart problems | High cholesterol

High or low blood pressure | Diabetes

Palpitations (abnormal or fast beating of the heart)

Psychological Problems

Treatment by a psychiatrist or counselor | Depression or unusual amounts of stress

Panic attacks

Cancer

Type of cancer | 15 lbs or more of weight loss

Pain

Pain in back of jaw (TMJ) | Migraine or other headaches

Low back or neck pain

Metabolic

Kidney problems	Dialysis
Liver disease	Low sugar (hypoglycemia)
Thyroid disorders	Syphilis or venereal disease
Lyme disease	Meningitis

Systemic Diseases

AIDS	Arthritis
Blood diseases, anemia	Fevers or swollen glands
Skin diseases	Lupus
Mononucleosis (Epstein Barr)	Tuberculosis

Eye Problems

Crossed eyes or lazy eye	Poor vision in one eye (amblyopia)

Neurological Problems

Bladder Problems	Tremor or incoordination
Loss of consciousness (faints-seizures)	Problems with sexual function

Pins and needles, numbness where?

Muscle weakness where?

Trouble speaking

Surgery: (check)

Appendix	Breast	Cataract	Carotid	C-Section
Ear	Gall Bladder	Hysterectomy	Prostate	Sinus
Stomach	Tonsils	Other:		

FAMILY HISTORY

Are there any **family members** with (check):

Headaches just like mine	Diabetes
Stroke	Heart disease or high blood pressure

Migraine headaches

Other diseases that run in the family (list)

PREVIOUS STUDIES Have you had any of these tests or procedures ? (check, date and result if known)

Eye Doctor

Dentist

Chiropractor

NEUROLOGICAL TESTS (check, date and result if known)

Carotid Doppler

Lumbar puncture (spinal fluid examination)

EEG (Brain Wave test for seizures)

GENERAL MEDICAL TESTS (check, date and result if known)

Recent general medical checkup?

Recent blood tests (Glucose, blood count)

Heart test (EKG, Stress test, Holter Monitor)

X-RAYS (check, date and result if known)

Cerebral Angiogram

MRI, MRA and/or CT scan of the head

Sinus X-rays or CT

Neck X-rays, CT or MRI

Chest X-ray