headache history

Please fill this out in addition to your Personal Medical History form.

Name_____ **Date of birth** ____/____/_____

Thinking as far back as you can remember, when did your headaches first start? Age _____

Do you think your headaches first started after an accident, illness or infection, or what? Please explain:

How often do they come (fill in):

____every day ____times per week ____times per month ____times per year

Do the headaches start at a certain time of the day (check one)?

____usually morning ____usually afternoon ____usually night ____it varies a lot

Have the headaches recently been changing?

____no, staying about the same _____ getting longer _____ getting stronger _____ getting closer together

The headaches last: _____seconds _____minutes _____hours _____days

Do the headaches wake you up from sleep? _____often _____occasionally _____hardly ever _____no

Does resting or sleeping relieve the headache? _____often _____occasionally _____hardly ever _____no

Do the headaches stop you from doing things? (like watching TV, going outside, housework, exercising)

_____often _____occasionally _____hardly ever _____no

Have you missed school or work because of a headache?

_____often _____occasionally _____hardly ever _____no _____does not apply

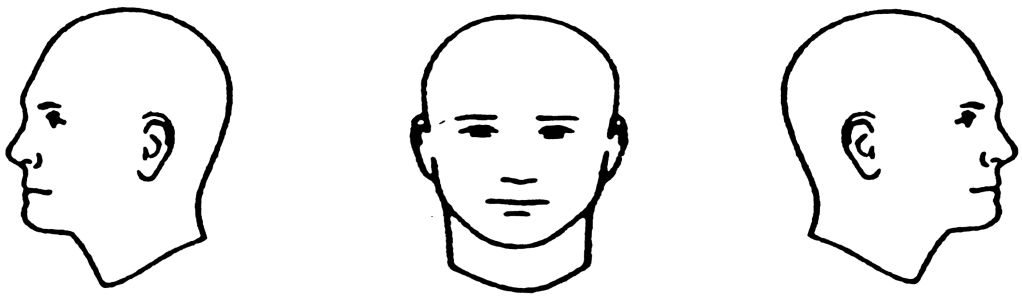
Describe the head pain you experience:

____ throbbing ____ pounding ____ tight ____ pressure ____ exploding

____ pulsating ____ constant ____ squeezing ____ sharp, knifelike ___ hat-band tenderness

____ other:

Please shade in the area where your headaches are usually located:



(left) (right)

The headaches are accompanied by:

__ diarrhea
__ dizziness
__ drooping eye lid
__ facial tenderness
__ fever
__ flushing on one side of the face
__ light sensitivity
__ noise sensitivity
__ passing out/ loss of consciousness
__ nausea or vomiting
__ neck stiffness
__ red, teary eye
__ runny/stuffy nose
__ ankle swelling
__ problem talking
__ problem with vision
__ weakness in (circle): face/ arm/ leg
__ numbness in (circle): face/ arm/ leg

Other symptoms:

Is your head pain triggered by any of the following:

___ alcohol
___ weather
___ bending over
___ blood pressure
___ head cold/ virus
___ certain foods: (which ones?)
___ coughing
___ stress/ anxiety/ depression
___ exertion
___ fatigue
___ heat/ hot shower
___ head movement
___ menstrual periods
___ missing a meal
___ msg (monosodium glutamate)
___ odors
___ salt
___ sex
___ time of year
___ swallowing
___ poor sleep
___ time of day

Injuries (please give kind of injury and date):

Head:	Neck:	Dental:

Do you think you have been exposed to these? (If you've never heard of them, you probably haven't!)

_____Carbon monoxide _____Syphilis or HIV _____Tuberculosis _____Parasites

Have you traveled outside USA? Locations and dates (year):

Which of the following medicines have you taken for headache: (circle)

Abilify	*Axert*	*Catapres*	*DHE (ergot)*	*Feverfew*	*Limbitrol*
Adipin	*Axotal*	*Corguard*	*Duradrin*	*Fiorinal*	*Lithium*
Acetaminophen	*Aventyl*	*Codeine*	*Duragesic*	*Fioricet*	*Liorisal*
Advil	*Baclofen*	*Cymbalta*	*Ecotrin*	*Flexeril*	*Lopressor*
Alleve	*Bellergal*	*Cyproheptadine*	*Effexor*	*Gabapentin*	*Lortabs*
AlkaSeltzer	*Beta-blocker*	*Darvocet/ Darvon*	*Elavil*	*Ibuprofen*	*Lorcet*
Amerge	*Blockadren*	*Datril*	*Empirin*	*Imitrex*	*Ludiomil*
Amitriptyline	*Bufferin*	*Dapro*	*Ergomar*	*Inderal*	*Lyrica*
Anacin	*Butterbur*	*Desyril*	*Ergostat*	*Indocin*	*Magnesium*
Anafranil	*Cafergot*	*Dilantin*	*Esgic*	*Indomethacin*	*Marplan*
Antihistamines	*Calan*	*Decongestants*	*Equigesic*	*Isoptin*	*Maxalt*
Asendin	*Cardene*	*Demerol*	*Excedrin*	*Lamictal*	*Methadone*
Aspirin	*Cardizem*	*Depakote*	*Fentanyl patch*	*Lexapro*	*Mexetil*

Micranin	*Nubain*	*Percogesic*	*Sansert*	*Topamax*	*Verapamil*
Midol	*Nuprin*	*Periactin*	*Sinequan*	*Toprol*	*Verelan*
Midrin	*Oxygen*	*Petadolex*	*Sinutab*	*Torecan*	*Viskin*
Migranol	*Oxycontin*	*Phenergan*	*Skelaxin*	*Trexan*	*Vivactyl*
Motrin	*Pamelor*	*Phrenilin*	*Soma*	*Triavil*	*Vicodin*
Naprosyn	*Panadol*	*Procardia*	*Stadol Nasal Spray*	*Trilifon*	*Wellbutrin*
Neurontin	*Parafon Forte*	*Propranolol*	*Sumatriptin*	*Trileptal*	*Wigraine*
Nimodipine	*Parnate*	*Prozac*	*Surmontil*	*Tylox*	*Zomig*
Norflex	*Paxil*	*Reglan*	*Talwin*	*Tylenol*	*Zonegran*
Norgesic	*Pertofrane*	*Relpax*	*Tenormin*	*Tylenol #3 or #4*	*Zoloft*
Norpramin	*Percocet*	*Robaxin*	*Thorazine*	*Vanquish*	
Nortriptyline	*Percodan*	*Serzone*	*Timonol*	*Venlafaxine*	

Which of the following has your health has been affected by (circle, date):

Heart problems	Chronic spinal pain	"Mono"
High cholesterol	Fibromyalgia	Lyme disease
High blood pressure	TMJ syndrome	Meningitis
Low blood pressure	HIV-AIDS	Tuberculosis (TB)
Diabetes	Rheumatoid arthritis	History of crossed eyes or lazy eye
Heart palpitations	Osteoarthritis	Poor vision in one eye (amblyopia)
Weight loss of 15 lbs or more	Psoriasis	Bladder problems
Kidney disease	Anemia	Tremor or incoordination
Liver problems	Blood disorder	Passing out (fainting or seizures)
Low blood sugar (hypoglycemia)	Lupus or other autoimmune problem	Pins and needles, numbness (where?)
Thyroid disorders	Fevers	Muscle weakness (where?)
Depression or bipolar disorder	Swollen glands (neck, armpit, or groins)	Problems with sexual functioning
Anxiety or panic	History of syphilis or other STD	Trouble with speech
Cancer (what kind?)		

Have you had any of these?

Eye doctor visit (Date: ____/____/_____)	EEG (brain wave test) (Date: ____/____/_____)
Dentist visit (Date: ____/____/_____)	Blood tests (blood count, blood sugar) (____/____/_____)
Chiropractor visit (Date: ____/____/_____)	Carotid Doppler (neck ultrasound) (____/____/_____)
Headache, neurology, or pain doctor (____/____/_____)	Heart tests (EKG, stress test, etc. (____/____/_____)
Psychologist or psychiatrist (____/____/_____)	General medical checkup (Date: ____/____/_____)
Lumbar puncture (spinal tap) (Date: ____/____/_____)	12-Step or drug/ alcohol treatment (____/____/_____)