

Patient Name:	Today's Date:
DOB:	Age:

Office Use:

How old were you when the headaches started?
How often do the headaches occur? <input type="checkbox"/> daily _____ times a week _____ times a month
How long do the headaches last? _____ minutes _____ hours <input type="checkbox"/> constant

Where are your headaches located? (list all that apply):		
<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Both
<input type="checkbox"/> Back of your head, upper part of your neck, occipital		
<input type="checkbox"/> Top of your head, vertex		
<input type="checkbox"/> Sides of your head, temples		
<input type="checkbox"/> Front of your head, forehead		
<input type="checkbox"/> Front of your face, sinuses		
<input type="checkbox"/> Behind your eyes, ophthalmic		

Do you have any of the following associated symptoms DURING your headaches?	
<input type="checkbox"/> Y <input type="checkbox"/> N	Is your headache pulsating or pounding?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do your headaches increase with exercise?
<input type="checkbox"/> Y <input type="checkbox"/> N	Are you sensitive to LIGHT (photophobia)?
<input type="checkbox"/> Y <input type="checkbox"/> N	Are you sensitive to NOISE (phonophobia)?
<input type="checkbox"/> Y <input type="checkbox"/> N	Are you sensitive to ODORS (osmophobia)?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have NAUSEA?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you ever VOMIT? If yes, when was the last time? / /
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you see flashes of light (scintillations)?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you see spots or zig-zag lines (fortification spectra)?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you ever experience tingling/ numbness of face or hands?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does your eyelid droop?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does your eye turn RED or TEAR?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does your nose run?
<input type="checkbox"/> Y <input type="checkbox"/> N	Is your headache worse in the MORNING?
<input type="checkbox"/> Y <input type="checkbox"/> N	Is your headache worse with coughing or bending forward?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you experience DOUBLE vision?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have BALANCE problems?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does it hurt to open your MOUTH wide?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have POPPING or CLICKING with your mouth opening?
<input type="checkbox"/> Y <input type="checkbox"/> N	Is your headache better (almost immediately) with LYING down?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have a history of TRAUMA to the head or neck?

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<input type="checkbox"/> Y <input type="checkbox"/> N	Have you had prior craniectomy or surgery on the head? If yes, when? / /
<input type="checkbox"/> Y <input type="checkbox"/> N	Are there any foods that trigger your headache? If yes, what:
<input type="checkbox"/> Y <input type="checkbox"/> N	Are you familiar with foods that may trigger headache?
<input type="checkbox"/> Y <input type="checkbox"/> N	Is there ANYTHING not mentioned yet that triggers your headache? If yes, what:
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you been treated before in headache or pain clinics/centers?
<input type="checkbox"/> Y <input type="checkbox"/> N	Is there ANYTHING that helps relieve your headache? If yes, what:

Prior MEDICATIONS tried		Please List:
<input type="checkbox"/> Y <input type="checkbox"/> N	Tryptans (e.g. Imitrex)	
<input type="checkbox"/> Y <input type="checkbox"/> N	Anti-depressants	
<input type="checkbox"/> Y <input type="checkbox"/> N	Anti-seizure	
<input type="checkbox"/> Y <input type="checkbox"/> N	Beta-blockers (e.g. Inderal)	
<input type="checkbox"/> Y <input type="checkbox"/> N	Calcium Channel Blockers	
<input type="checkbox"/> Y <input type="checkbox"/> N	Hormone replacement	
<input type="checkbox"/> Y <input type="checkbox"/> N	Methysergide (e.g. Sansert)	
<input type="checkbox"/> Y <input type="checkbox"/> N	Anti-inflammatories	
<input type="checkbox"/> Y <input type="checkbox"/> N	Tylenol	
<input type="checkbox"/> Y <input type="checkbox"/> N	Opioids/Narcotics	
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you ever required any Emergency Room (ER) visits for your headaches?	

FEMALES ONLY:	
<input type="checkbox"/> Y <input type="checkbox"/> N	If past PREGNANCY, did headaches improve during pregnancy?
If menstruating:	
<input type="checkbox"/> Y <input type="checkbox"/> N	Are you regular?
<input type="checkbox"/> Y <input type="checkbox"/> N	Are your headaches associated with your menstrual cycle?
<input type="checkbox"/> Y <input type="checkbox"/> N	Are you on birth control pills?
<input type="checkbox"/> Y <input type="checkbox"/> N	Are you on birth control patch?
<input type="checkbox"/> Y <input type="checkbox"/> N	Are you on other birth control medicine?
<input type="checkbox"/> Y <input type="checkbox"/> N	Any recent CHANGES with your birth control?
If non-menstruating:	
<input type="checkbox"/> Y <input type="checkbox"/> N	Are you menopausal?
<input type="checkbox"/> Y <input type="checkbox"/> N	Are you on hormone replacement therapy?
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you been treated with Tamoxifen, Danazol, Bromocriptine?

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