Name:_____Date:_____

Street:_____City:_____State:_____Zip:_____

Telephone: (_____)_____-_____ Height:_____ Weight:_____ Age:_____

DOB:_____ Birthplace:_____

Sex: □ Male □ Female Marital Status:_____

Education:_____

Occupation:_____Job Title:_____How Long:_____

Spouse's occupation:_____

Name(s) and age(s) of children:_____

_____

1. Headache History:

   How many types of headaches do you have?_____

   Please give a brief description of each type of headache:_____

   _____

   At what age did your headaches begin?_____

2. Frequency:

   Headaches occur_____times □ Daily □ Weekly □ Monthly □ Other (check one)

   Are they increasing? □ Yes □ No

   How many headache free days do you have per week?_____ per month?_____

3. Location:

   Headache starts: □ Left side □ Right side □ Either side □ All over head

   □ Face/Jaw □ Neck □ Other (please explain)_____

   Headache: □ Usually stays in one place □ Sometimes moves around

   □ Often moves around □ Other (please explain)_____

4. Duration:

   Headaches last: _____hours/days if not treated

   _____ hours/days if not treated immediately

   _____ hours/days if treated after they are severe

5. Precipitating Factors:

   Headaches can be brought on by: (check all that apply)

□ Fatigue	□ Oversleeping	□ Certain medications	□ Coughing
□ Under sleeping	□ Lying down	□ Exercise	□ Exertion
□ Sexual activity	□ Stooping	□ Hormonal Changes	□ Different seasons
□ Missing a meal	□ Changes in weather	□ Bright lights	□ Stress/tension
□ Chewing/talking	□ Loud noise	□ Relief from stress	□ Shaving or touching face

   □ Odors (list):_____

   □ Foods (list):_____

   □ Alcohol (list):_____

   □ Other (list):_____

6. Prodrome: Premonition before headache
   - ☐ Food cravings ☐ Yawning ☐ Euphoria ☐ Mood swings
   - ☐ Irritability ☐ Depression ☐ Fatigue ☐ Burst of energy

7. Warning before headache:
   - ☐ Flashing lights ☐ Dizziness/light headed ☐ Double vision
   - ☐ Nausea/vomiting ☐ Tingling or numbness in leg or arm ☐ Ringing in the ears
   - ☐ Blind spots ☐ Feeling of tightness around head ☐ Blurred vision
   - ☐ Weakness of a limb ☐ Zigzag lines ☐ Decreased level of consciousness
   - ☐ Uncoordinated movements ☐ Decreased hearing ☐ Visual halos around objects
   - ☐ Speech disturbances ☐ Other:_____

8. Seasonality:
   Headaches are more frequent in: ☐ Winter ☐ Summer ☐ Spring ☐ Fall ☐ Non-seasonal

9. Hormonal: (Women only)
   Are your headaches affected by:

	Yes	No	
Menstrual cycle	☐	☐	Please explain:_____
Pregnancy	☐	☐	_____
Premenstrual	☐	☐	_____
Ovulation	☐	☐	_____
Birth Control Pills	☐	☐	_____
Menopause	☐	☐	_____
Hormone Replacement	☐	☐	_____

10. Pain Type: Headache pain is:
    - ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Sharp ☐ Piercing
    - ☐ Pounding ☐ Pulsating ☐ Crushing ☐ Stabbing ☐ Squeezing ☐ Boring
    - ☐ Tight pressure (non-pulsating) or tight band ☐ Jabs or jolts (brief____repeated____continuous____)

11. Severity: Headache pain is:
    If more than one type of headache, check all that apply:
    - ☐ Mild to moderate ☐ Severe ☐ Very severe ☐ Unbearable

    Headache prevents normal activities such as work? ☐ Yes ☐ No
    If yes, ☐ rarely ☐ occasionally ☐ often ☐ unable to work at all

    What time of day do headaches occur?_____

12. Family History:
    Relatives with headaches: ☐ Mother ☐ Father ☐ Sister ☐ Brother
    ☐ Grandparents ☐ Aunts or Uncles
    If so, please list family member, age, and brief description of headaches:_____
    _____
    _____

13. Associated Symptoms: Symptoms accompanying headache (check all that apply)
    - ☐ Nausea/vomiting ☐ Swollen eyelid ☐ Light sensitivity ☐ Dizziness
    - ☐ Droopy eyelid ☐ Visual disturbances ☐ Sound sensitivity ☐ Red eye
    - ☐ Nasal congestion ☐ Insomnia ☐ Constriction of pupil ☐ Numbness
    - ☐ Hearing change ☐ Facial swelling ☐ Stiff neck ☐ Early morning awakening
    - ☐ Skin changes on face ☐ Other:_____

    _____

What time of day do you usually go to bed?_____
What time do you get up in the morning?_____
Do you feel refreshed after sleeping overnight?_____

14. Previous Care:
Which doctor(s) have you seen for headache?_____
_____

What diagnosis tests/x-rays for headaches have you had in the past?
☐ CT Scan ☐ MRI Scan ☐ Sinus x-rays ☐ EEG ☐ Lumbar puncture
☐ Neuropsychiatric testing ☐ Other:_____

Medications previously taken for headaches?
Preventive medications:_____
_____
Abortive medications:_____
_____
Other:_____
_____

Medications presently taking for headaches?
Preventive medications:_____
_____
Abortive medications:_____
_____
Other:_____
_____

Other treatment, such as biofeedback for headaches?_____
Current medications (other than those for headache):_____
_____
_____
Allergies to medications:_____
Hospitalization (other than normal pregnancy):_____
_____

Do you have a history of stroke? ☐ Yes ☐ No

Do you have a history of seizures? ☐ Yes ☐ No

Do you have any history of serious psychiatric illness? ☐ Yes ☐ No

Do you have any history of head injury? ☐ Yes ☐ No
Date of injury:_____
How soon did headaches begin after injury?_____
Did you ever have headaches before the injury? ☐ Yes ☐ No

Do you have a history of alcohol or drug abuse? ☐ Yes ☐ No
☐ Prescribed ☐ Un-prescribed

Is there any special reason why you are seeking treatment for your headaches at this particular time?_____
_____
_____
_____