Name: ______________________________________ Date: _______________________

Welcome to the JEFFERSON HEADACHE CENTER

Patient History

Name: _____________________________ D.O.B.: ___________ Age: _____ ☐ M ☐ F

Address: ___________________________ Birthplace: _____________________________

____

Phone: (H)____________________ (W)____________________ (C)__________________

Marital Status: ☐S ☐ M ☐ W ☐DIV ☐SEP Religion: _____________ Race: ____________

Referred by: ☐primary care physician ☐other neurologist ☐other: ___________

Family Physician: _______________________________ Phone: ______________________

Address: ____

Reason for visit? ____

Headache History

Do you have more than one headache type? ☐ Yes ☐ N

HEADACHE #1

1. Are you ever headache free: ☐ Yes ☐ No

☐ Pregnancy ☐ Vacation ☐ Weekends ☐ Random ☐ Remission ☐ Other: _____________

2. Onset of First Headache:

Headaches started ____ years ago. I was ____ years old.

3. Is there anything that caused your headache to start?

☐ not known ☐ injury ______________

☐ menarche (first period) ☐ pregnancy

☐ other: _____________

Current pattern: ☐ sudden ☐ rapid ☐ gradual ☐ varies ☐ morning ☐ afternoon ☐ evening

☐ awakens from sleep

When are they most frequent: ☐ weekends ☐ weekdays ☐ vacation ☐ seasonal: __________

Name: ____ Date: ________________________

4. Frequency: How many headaches per:

☐ #/day ☐ #/week ☐ #/month ☐ # per year ☐ # of lifetime attacks ☐ continuous

Are they increasing in frequency: ☐ Yes ☐ No
If continuous, for how long? _________

5. Duration: (how long do they last?)
Lasts ___mins ___hours ___days with medication

Lasts ___mins ___hours ___days without medication

6. Severity: (how bad is the pain on a scale of 0 to 10; 0 is no pain, 10 is the worst)
Lowest and highest level of pain for this headache type: Low ________ High________
Usual severity of this headache type: ________

Worse with menses? ☐ Yes ☐ No

7. Location:

☐ temples ☐ eye ☐ back of head ☐ side of head ☐ front of head

☐ around head ☐ ear ☐ neck ☐ jaw ☐ Top/crown of head ☐ other: _______

Is your headache:

☐ right-sided

☐ left-sided

☐ both-sided

☐ varies

Does it change sides:

☐ between attacks

☐ during attacks

☐ both between and during

Character:

☐ throbbing/pulsing

☐ achy

☐ tight

☐ dull

☐ stabbing

☐ pressure

☐ burning

☐ searing

☐ shooting

☐ other: _________________

8. Activity that worsens headache:

☐ bending over

☐ walking

☐ climbing steps

☐ exercise

☐ none

☐ other:______________

Headache disability during or after an attack:

☐ normal activity

☐ slight decrease in function

☐ moderate decrease in function

☐ severe decrease in function

☐ confined to bed

Name: ______________________________________ Date: _______________________

9. Associated Symptoms:

☐ nausea ☐ increase urination ☐ increase appetite

☐ vomiting ☐ sores/stiff neck ☐ decreased appetite

☐ sensitive to: ☐ ringing in the ears ☐ eye-tearing (Rt, Lt, Both)

☐ lights ☐ blurred vision ☐ nose congested (Rt Lt Both

☐ sounds ☐ anxiety ☐ runny nose (Rt, Lt, Both

☐ odors ☐ irritability ☐ eye-redness (Rt, Lt, Both)

☐ diarrhea ☐ concentration problems ☐ drooping eyelid (Rt, Lt, Both)

☐ constipation ☐ memory problems ☐ change in pupil (Rt, Lt, Both)

☐ insomnia ☐ confusion ☐ lightheaded, dizziness

10. Aura: Visual (Do you have these symptoms before your headache begins?)

☐ loss of vision in one eye ☐ tunnel vision

☐ flashing lights ☐ loss of vision on one side ☐ double vision

☐ zigzag lines ☐ total blindness ☐ other: __________________

Do the symptoms spread? ☐ Yes, spreads slowly ☐ No, begins all at once

The visual symptoms start: ☐ before the headache pain ☐ during the headache pain (same time)

☐ both before and during

The visual symptoms last a total of: _____________.

If you have more than one symptom, do they happen: ☐ one after the other ☐ all at once

Do you have a visual aura without headache pain? ☐ Yes ☐ No

11. Aura: Sensory (Do you have these symptoms before your headache begins?)

☐ numbness/tingling- right ☐ dizziness/unsteadiness ☐ one-sided weakness

☐ numbness/tingling- left ☐ vertigo ☐ general weakness

☐ numbness/tingling- both ☐ light headedness ☐ speech difficulty

☐ unable to speak ☐ other:___________________________________

Does the sensory aura spread? ☐ Yes, spreads slowly ☐ No, begins all at once

The sensory aura altogether lasts: _____.

How long does the aura last before onset of head pain? _____.

How long does the aura and head pain last, if both occur at the same time? _____.

If you have more than one symptom, do they happen: ☐ One after the other ☐ All at once

Do you experience sensory aura without headache pain? ☐ Yes ☐ No

Name: ____ Date: ________________________

12. Premonitory Symptoms (you experience one or more of these symptoms before onset of headache):

☐ heightened feeling of wellness
☐ hyperactive
☐ extremely talkative
☐ depressed feeling
☐ irritability
☐ sluggish
☐ drowsy
☐ restless
☐ dizziness
☐ difficulty concentrating
☐ sensitive to light
☐ sensitive to odors
☐ sensitive to sound/noise
☐ excessive yawning
☐ neck stiffness
☐ food cravings
☐ weakness
☐ difficulty with speech
☐ increased appetite
☐ decrease appetite
☐ feeling cold
☐ diarrhea
☐ constipation
☐ extremely thirsty
☐ increased urination
☐ fluid retention
☐ other: ____________

13. Provoking Factors: (things that bring on a headache)

Food/beverage: ☐ fasting ☐ chocolate ☐ caffeine ☐ nitrates ☐ MSG ☐ alcohol
☐ other: ____________________

Physical exertion: ☐ coughing ☐ talking ☐ chewing ☐ exercise ☐ sexual intercourse

Hormonal: ☐ pregnancy ☐ menopause menses: ☐ before ☐ during ☐ after

Stress: ☐ work ☐ home ☐ family ☐ spouse ☐ school ☐ other:________________

Environmental: ☐ allergies ☐ weather changes ☐ altitude ☐ sunlight ☐ other: _____________

Sleep: ☐ lack of sleep ☐ too much sleep ☐ change in wake/sleep

Other triggers: ____

14. Relieving Factors:

☐ lying down
☐ hot compress
☐ keeping active/pacing
☐ dark quiet room
☐ cold compress
☐ standing
☐ massage
☐ pregnancy
☐ other: ___________________

Name: ____ Date: ________________________

HEADACHE #2

1. Describe your second headache type: ____
Onset of Second Headache:
Headaches started ____ years ago. I was ____ years old.

2. Is there anything that caused your headache to start?

☐ not known ☐ injury _______________

☐ menarche (first period) ☐ pregnancy

☐ other: ______________

Current pattern: ☐ sudden ☐ rapid ☐ gradual ☐ varies ☐ morning ☐ afternoon ☐ evening

☐ awakens from sleep

When are they most frequent: ☐ weekends ☐ weekdays ☐ vacation ☐ seasonal: ___________

3. Frequency: (the number of attacks)

☐ #/day ☐ #/week ☐ #/month ☐ # per year ☐ # of lifetime attacks ☐ continuous

Are they increasing in frequency: ☐ Yes ☐ No

4. Durations: (how long do they last?)
Lasts ___mins ___hours ___days with medication

Lasts ___mins ___hours ___days without medication

5. Severity: (how bad is the pain on a scale of 0 to 10; 0 is no pain, 10 is the worse)
Lowest and highest level of pain for this headache type: Low ________ High________
Usual severity of this headache type: ________

6. Location:

☐ temples ☐ eye ☐ back of head ☐ side of head ☐ front of head

☐ around head ☐ ear ☐ neck ☐ jaw ☐ Top/Crown ☐ other: ___________

Is your headache:

☐ right-sided

☐ left-sided

☐ both-sided

☐ varies

Does it change sides:

☐ between attacks

☐ during attacks

☐ both between and during

Character:

Name: ______________________________________ Date: _______________________

☐ throbbing/pulsing ☐ pressure
☐ achy ☐ burning
☐ tight ☐ searing
☐ dull ☐ shooting
☐ stabbing ☐ other: ________________

7. Activity that worsens headache:
☐ bending over
☐ walking
☐ climbing steps
☐ exercise
☐ other:_______________

Headache disability during or after an attack:
☐ normal activity
☐ slight decrease in function
☐ moderate decrease in function
☐ severe decrease in function
☐ confined to bed

8. Associated Symptoms:

☐ nausea	☐ increase urination	☐ increase appetite
☐ vomiting	☐ sores/stiff neck	☐ decreased appetite
☐ sensitive to:	☐ ringing in the ears	☐ eye-tearing (Rt, Lt, Both)
☐ lights	☐ blurred vision	☐ nose congested (Rt, Lt, Both)
☐ sounds	☐ anxiety	☐ runny nose (Rt, Lt, Both)
☐ odors	☐ irritability	☐ eye-redness (Rt, Lt, Both)
☐ diarrhea	☐ concentration problems	☐ drooping eyelid (Rt, Lt, Both)
☐ constipation	☐ memory problems	☐ change in pupil (Rt, Lt, Both
☐ insomnia	☐ confusion	☐ lightheaded, dizziness

9. Aura: Visual (Do you have these symptoms before your headache begins?)

	☐ loss of vision in one eye	☐ tunnel vision
☐ flashing lights	☐ loss of vision on one side	☐ double vision
☐ zigzag lines	☐ total blindness	☐ other: __________________

Do the symptoms spread? ☐ Yes, spreads slowly ☐ No, begins all at once

The visual symptoms start: ☐ before the headache pain ☐ during the headache pain (same time)
☐ both before and during

The visual symptoms last a total of: ______________.

If you have more than one symptom, do they happen: ☐ one after the other ☐ all at once

Do you have a visual aura without headache pain? ☐ Yes ☐ No

10. Aura: Sensory

Name: ____ Date: ________________________

☐ numbness/tingling- right ☐ dizziness/unsteadiness ☐ one-sided weakness

☐ numbness/tingling- left ☐ vertigo ☐ general weakness

☐ numbness/tingling- both ☐ light headedness ☐ speech difficulty

☐ unable to speak ☐ other:___________________________________

Does the sensory aura spread? ☐ Yes, spreads slowly ☐ No, begins all at once
The sensory aura altogether lasts: _____.
How long does the aura last before onset of head pain? _____.
How long does the aura and head pain last, if both occur at the same time? _____.

If you have more than one symptom, do they happen: ☐ One after the other ☐ All at once

Do you experience sensory aura without headache pain? ☐ Yes ☐ No

Quality of Life Review:

1. My appetite is: ☐ increased ☐ decreased ☐ no change

My energy level is: ☐ increase ☐ decreased ☐ no change

My mood is: ☐ better ☐ worse ☐ no change

My mood can be described as: (check all that apply):

☐ anxious ☐ calm ☐ depressed ☐ euphoric ☐ irritable ☐ angry ☐ tearful ☐ other: ________

2. I get approximately ____ hours of sleep per night.

Check all that apply:

☐ I have no trouble falling asleep

☐ I have difficulty falling asleep

☐ I have trouble staying asleep

☐ I sleep too much

☐ I wake up during the night or early morning for no apparent reason

☐ I snore or have sleep apnea

  ☐ Do you wear CPAP/BIPAP yes no

☐ My headache awakes me

☐ I wake up with a headache

3. My sexual function is: (check all that apply)

☐ normal ☐ no change ☐ increased libido ☐ decreased libido ☐ no orgasms

☐ problem with erections ☐ other: _______________________

4. Headache's Effect on ability to function:

Name: ______________________________________ Date: _______________________

Record # of days missed per month of work/school and or social and family activities

☐ work productivity _____#/days/month missed

☐ school productivity _____#/days/month missed

☐ social/family activities _____ #/days/month missed

Previous Treatment and Testing:

1. Previous treatments: (please give name of provider, and if treatment helped)

☐ primary care provider ____

☐ neurologist ____

☐ otolaryngologist (ENT) ____

☐ dentist/dental ____

☐ chiropractor ____

☐ ophthalmologist ____

☐ neuro-ophthalmologist ____

☐ psychiatrist/psychologist ____

☐ biofeedback/relaxation ____

☐ physical therapy ____

☐ massage ____

☐ acupuncture/acupressure ____

☐ herbal/homeopathic medicine ____

☐ other ____

2. Previous Test: (Please give results and bring reports, films or CD's)

☐ head MRI

☐ MRA/MRV

☐ cervical MRI

☐ head CT

☐ other: ______________________

☐ EEG

☐ lumbar puncture

☐ EKG

☐ sleep study

Previous Headache Medication: (please check any medication that you have taken for your headache

Name: ____ Date: ________________________

and write the largest does you tried next to it)

Preventives:

[ ]Celexa [ ] Lexapro [ ]Luvox [ ]Paxil [ ]Prozac [ ] Zoloft

[ ]Elavil (amitriptyline) [ ] Imipramine [ ]Pamelor (nortriptyline) [ ]Other trycyclic

[ ]Cymbalta [ ]Effexor [ ] Nardil [ ]Parnate [ ]Remeron [ ]Serzone
[ ]Wellbutrin [ ] Zyban [ ]Buspar [ ] Savella [ ] Viibryd

[ ]Corgard [ ]Inderal (propranolol) [ ]Tenormin (atenolol) [ ]Timolol [ ]Metoprolol
[ ] Lisinopril [ ] Atacand [ ] Benicar

[ ]Calan (verapamil, verlan, isoptin) [ ]Cardizem (diltiazem) [ ]Procardia (nifedipine)
[ ]Other Ca blocker

[ ]Depakote [ ]Dilantin (phenytoin) [ ]Gabitril [ ]Keppra [ ]Lamictal [ ] Lyrica
[ ]Neurontin [ ]Tegretol (carbamazepine) [ ]Topamax [ ]Trileptal [ ]Zonegran [ ]Other

[ ]Lithium [ ]Risperdal [ ]Abilify [ ]Seroquel [ ]Zyprexa [ ]Trazodone

[ ]Ativan [ ]Buspar [ ] Klonopin (clonazepam) [ ] Valium(diazepam)
[ ]Xanax (alprazolam) [ ]Zanaflex

[ ]Trigger point injections [ ]Greater Occipital Nerve blocks [ ] Botox injections [ ]Other

[ ]Celebrex [ ]Vioxx [ ]Indocin [ ]Mexilitine [ ]Methergine [ ]Cyproheptadine []Sansert

[ ]Nonsteroidal antiinflammatory drug(s) [ ]Other

[ ]Coenzyme Q [ ]Feverfew [ ]Magnesium [ ]Melatonin [ ]Petadolex
[ ]Vitamin B2 (Riboflavin)

[ ] Amantidine [ ] Namenda [ ] Minocycline

Abortives:

[ ]DHE [ ]Migranal [ ]Bellergal [ ]Cafergot [ ]Wigraine

[ ]Ergotamine suppositories

[ ]Amerge [ ]Axert [ ]Frova [ ]Imitrex tabs [ ]Imitrex nasal spray

[ ]Imitrex inj [ ] Treximet [ ]Maxalt [ ]Relpax [ ]Zomig

[ ]Codeine [ ]Darvocet [ ]Darvon [ ]Demerol [ ]Dilaudid

[ ]Duragesic patch [ ]Methadone [ ]Morphine [ ]MS Contin

[ ]MSIR Oxy [ ]R/Oxycodone [ ]OxyContin [ ] Percocet [ ]Percodan

[ ]Ultram [ ]Ultracet [ ]Stadol/Butorphanol [ ]Vicodin [ ]Hydrocodone

[ ] Other

[ ]Fioricet [ ]Fioricet with codeine [ ]Fiorinal [ ]Fiorinal with codeine [ ]Lortab

Name: ______________________________________ Date: _______________________

Abortives Con't:

[ ]Advil (ibuprofen) [ ] Aleve [ ]Anaprox (naproxen sodium) [ ]Cataflam [ ]Celebrex

[ ]Daypro [ ]Indocin (indomethacin) [ ]Motrin (ibuprofen) [ ]Naprosyn [ ]Orudis

[ ]Toradol (ketorolac) [ ]Relafen (ketoprofen) [ ]Voltaren (diclofenac) [ ]Vioxx

[ ] Etodolac [ ] Meloxican/mobic [ ] Cambia

[ ]Benadryl (diphenhydramine) [ ]Compazine (prochlorperazine) [ ]Droperidol [ ] Haldol

[ ]Navane (thiothixene) [ ]Phenergan (promethazine) [ ]Reglan (metoclopramide)

[ ]Thorazine (chlorpromazine) [ ]Tigan [ ]Zofran [ ]Zyprexa [ ] Other

[ ]Medrol Dose Pak [ ]Prednisone (prednisolone) [ ]Decadron (dexamethasone) [ ]Soma

[ ]Aspirin [ ]Tylenol [ ] Excedrin [ ]Flexeril [ ]Midrin

Medication List

Current medicines.

Please list **ALL** medications currently taken; include over-the-counter medications and vitamins

Medication	Daily Dosage	Side Effects Results
1		
2		
3		
4		
5		
6		
7		

Medication	Daily Dosage	Side Effects Results
8		
9		
10		
11		
12		
13		
14		

Please list any serious side effects from any medications (include name of drug and reaction);

____

____

____

Name: ______________________________ Date: __________________

Allergies:

1. Allergies: ☐ drugs ☐ dye/iodine ☐ latex ☐ other

Please list allergies:____

If allergic, what reaction did you have:
☐ skin ☐ stomach ☐ breathing ☐other:____________

Past Medical History:

1.General Health: ☐ excellent ☐ good ☐ fair ☐ poor

2. Have you had any of the following medical problems?

☐ diabetes	☐ arthritis	☐ asthma
☐ hypertension	☐ cervical neck/spine problem	☐ ulcer/gastrointestinal problem
☐ heart disease	☐ skin problems	☐ kidney/renal disease
☐ stroke/transient ischemic	☐ cancer	☐ infectious disease
☐ seizure/epilepsy	☐ hepatitis/liver disease	☐ gyn problem
☐ head injury	☐ deep vein thrombosis/phlebitis	☐ psychiatric
☐ ear, nose, and throat problem	☐ thyroid disease	☐ hospitalization
☐ dental problems	☐ pulmonary disease	☐ other: __________

3. Have you ever been hospitalized or had surgery? (list reason, date, hospital)

____

4. Menstrual History:

Menarche (age of onset): ______

Are you still menstruating? ☐ Yes ☐ No

Last menstrual period: _______
Cycle length: ____________
Character: ______________
Premenstrual symptoms: _______________________________________

Menses occur monthly: ☐ Yes ☐ No
If not monthly, every: ________________
Reason for menopause: _______________

5. Obstetrical History:

☐ total pregnancies	☐ living
☐ full term babies	☐ induced abortion
☐ premature	☐ miscarriage/spontaneous abortions

Are you sexually active? ☐ Yes ☐ No
Current method of contraception: ____________________

Name: ______________________________________ Date: _______________________

6. Social History:

Living in: ☐ home ☐ apartment ☐ other: ___________

Living in household: ☐ # of people ☐ # of children ☐ # of children <18

☐ spouse ☐ partner ☐ parents ☐ roommates

Education: ☐ some high school ☐ HS graduate or GED ☐ some college ☐ college degree

☐ post graduate school ☐ grade:____ ☐ other: _______________________

Employment Status: ☐ part-time ☐ full-time ☐ retired ☐ disability
If disabled, why? ___________________________ Other: ___________________
Type of work: ______________________________ Occupation: _____________________

7. Risk Factors:

Alcohol Intake Amount per: ☐ day ☐ week ☐ month ☐ none

Year began: ______________ Year stopped: ______________ Recovery ____________

Drug use: ☐ marijuana ☐ cocaine/crack ☐ heroin ☐ other: ____________________________

Year began: ______________ Year stopped: ______________

Current smoking history:

I smoke___ cigarette per ☐ day ☐ week ☐ month

I smoke ___ cigars per ☐ day ☐ week ☐ month

I drink ___ caffeinated beverages per ☐ day ☐ week

Past:

Year (_____) you stopped smoking

Amount/Frequency: __________

Number of years? __________

8. Lifestyle Factors:

Do you exercise? ☐ No ☐ Yes _____ X a week.
What type of exercise? ____

Are you on a special diet? ☐ No ☐ Yes

Any recent weight loss? ☐ No ☐ Yes Weight gain? ☐ No ☐ Yes
Describe diet or weight change: ____

<u>Family History:</u>
Do you know of any blood relative who has had:

☐ heart disease ☐ hypertension ☐ stroke ☐ headache (migraine, cluster)

☐ neurologic disease (seizures, alzheimer's) ☐ arthritis ☐ asthma ☐ cancer

☐ diabetes ☐ liver disease ☐ thyroid disease ☐ alcohol/psych disease (depression)

Please explain: ____

Name: ______________________________ Date: ____________________

Family History

Give age & current health status (good/fair/poor). If deceased, give age and cause of death.

Father ______________________________ **Spouse** ______________________

Mother ______________________________ **Children** ______________________

Siblings ____

Review of Systems:

11. Have you been having any of the following symptoms not associated with your headache?

☐ No ☐ Yes

Fever	☐	yes	☐	no	Shortness of breath	☐	yes	☐	no	Tremors	☐ yes ☐ no
Fatigue	☐	yes	☐	no	Nausea	☐	yes	☐	no	One-sided weakness	☐ yes ☐ no
Double vision	☐	yes	☐	no	Constipation	☐	yes	☐	no	Loss of consciousness	☐ yes ☐ no
Flashing lights	☐	yes	☐	no	Abdominal pain	☐	yes	☐	no	Difficulty falling asleep	☐ yes ☐ no
Loss of vision	☐	yes	☐	no	Frequent urination	☐	yes	☐	no	Difficulty staying asleep	☐ yes ☐ no
Tearing	☐	yes	☐	no	Irregular periods	☐	yes	☐	no	Anxiety	☐ yes ☐ no
Blurry vision	☐	yes	☐	no	Neck pain	☐	yes	☐	no	Recent weight loss	☐ yes ☐ no
Congestion	☐	yes	☐	no	Muscle soreness	☐	yes	☐	no	Recent weight gain	☐ yes ☐ no
Ringing in the ear	☐	yes	☐	no	Rash	☐	yes	☐	no	Heat or Cold intolerance	☐ yes ☐ no
Chest pain	☐	yes	☐	no	Cold hands and feet	☐	yes	☐	no	Bruise easily	☐ yes ☐ no
Rapid heartbeats	☐	yes	☐	no	Dizziness	☐	yes	☐	no	Hay fever symptoms	☐ yes ☐ no

You can use this space to describe anything you feel is important that was not covered in this questionnaire.