



The Westchester Headache Center

HEADACHE HISTORY

Please print

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____

Patient Home Tel. #: _____ Sex: _____ Marital Status: _____

Address: _____

City: _____ State _____ Zip: _____

BEGAN:

1. When did your headaches start? ____ this year, ____ 1-5 years ago, ____ 5-more years ago.
2. At what age did your headaches start? _____

CAUSE:

3. Did you have an accident or injury that may have started your headache?
4. Do you feel that something else in your life may have started them?
Is it ____ menstruation, ____ emotional crisis, ____ medical illness.

FREQUENCY:

5. How often do they occur? ____ times per day, ____ times per week, ____ times per month.

LOCATION:

6. Where are they located?
____ left side, ____ right side, ____ all over head ("hatband"), ____ face / jaw.
7. Do they usually stay in one place or do they move around?
____ stationary, ____ sometimes move around, ____ often move around.

PINPOINTING FACTORS THAT INFLUENCE MY HEADACHES:

8. When I have headaches I:

(Check all that apply)

- _____ Have trouble falling asleep
- _____ Wake up and stay awake for awhile
- _____ Bright lights bother me
- _____ Loud sounds bother me
- _____ Have ringing in my ears
- _____ One eye tears
- _____ Both eyes tear
- _____ Certain odors bother me
- _____ My vision blurs
- _____ Lose my appetite
- _____ Have nausea
- _____ Have vomiting
- _____ Have a runny or stuffed-up nose
- _____ Have flushing on one side of face
- _____ Feel light-headed or dizzy
- _____ My hands or feet tingle or feel numb
- _____ Have a stiff or sore neck
- _____ Prefer to be alone
- _____ Can't go to work
- _____ Must leave work early
- _____ Feel tense and irritable

My headaches are worse if I:

(Check all that apply)

- _____ Drink alcohol
- _____ Cough, sneeze or move my bowels
- _____ Run or exercise

DURATION:

9. Are your headaches continuous regardless of treatment? ____yes, ____no

If not, how long do they usually last? (Please answer all 3 parts to the question.)

If not treated, last: ____0-4 hours, ____4-72 hours, ____longer than 72 hours.

If treated immediately, last: ____0-4 hours, ____4-72 hours, ____longer than 72 hours.

If treated after they are severe: ____0-4 hours, ____4-72 hours, ____longer than 72 hours.

10. Have you ever been free of headaches? ____yes, ____no

PRECIPITATING FACTORS:

11. My headaches are often brought on by:

- Fatigue Certain foods Menstruation Washing
 Lying down, Stress/Tension Alcohol Coughing
 Chewing Stooping Oversleeping Certain medications
 Shaving Talking

HORMONAL (Women Only):

12a. Are your headaches affected by your menstrual cycle?

- yes no not applicable

12b. Were your headaches affected by pregnancy?

- If yes, are they better, worse, not applicable

SEASONAL:

13. Are your headaches more frequent in the (check all that apply)

- spring summer fall winter

PRODROME/AURA:

14. Do you have any warnings/symptoms of headache for a period of time greater than 1 hour before the headache begins? yes no

15. If you have any warning (lasting 1 hour or less) that a headache is coming, please indicate the warnings before a headache (check all that apply):

- halos around lights upset stomach flashing lights light headed
 blind spot feeling of tightness dizziness other

PAIN TYPE:

16. How would you describe your usual headache (check all that apply)?

- Pain is:* throbbing dull sharp
 tight band stabbing burning

SEVERITY:

17. Please check the item that best describes the severity of your headache pain.

- The headache is mild moderate severe Intolerable

18. Please check the statement which describes your activity level.

I can continue with my normal activities

- 0-25% 26-50% 51-75% 76-100% of the time.

18. cont'd.

My normal activities are impaired and I am not as productive as usual...

____ 0-25% ____ 26-50% ____ 51-75% ____ 76-100% of the time.

I must leave what I am doing and rest for a while...

____ 0-25% ____ 26-50% ____ 51-75% ____ 76-100% of the time.

I am totally incapacitated and must go to bed...

____ 0-25% ____ 26-50% ____ 51-75% ____ 76-100% of the time.

FAMILY HISTORY:

19. Please indicate if any blood relatives have severe headaches.

Maternal - Mother's side: ____ Mother ____ Aunt ____ Uncle ____ Grandparent
____ Cousin ____ distant relative

Paternal - Father's side: ____ Father ____ Aunt ____ Uncle ____ Grandparent
____ Cousin ____ distant relative

EFFECTS OF HEADACHE:

20. Since I've had headaches, I have...

____ quit work ____ seen a psychiatrist ____ had marital problems
____ feel life if worthless ____ none of the above.

PREVIOUS CARE:

21. If a doctor has treated you before for your headaches, please provide the following:

Physician's name: Phone Fax

City State

Physician's name: Phone Fax

City State

TESTS /X-RAYS:

22a. What tests and x-rays have you had relating to your headaches?

____ MRI _____ date(s) taken

____ CT _____ date(s) taken

____ Spinal Tap _____ date(s) taken

22b. Abnormal blood tests (if applicable):

Abnormal results found with (check all that apply):

_____ blood count _____ chemistry tests _____ liver test _____ HIV

_____ venereal disease _____ other

22c. Psychological testing (if applicable):

Did the results of testing indicate that you (check all that apply):

_____ did not have a psychological problem _____ were depressed _____ were suicidal

_____ were anxious _____ were manic _____ I don't know the test results

MEDICATIONS:

23. What medications do you take or have you taken for your headaches?

Ever Taken:

Acute Medications (check all that apply):

_____ Sumatriptan (Imitrex) _____ Naratriptan (Amerge) _____ Rizatriptan (Maxalt)

_____ Almotriptan (Axert) _____ Zolmitriptan (Zomig) _____ Frovatriptan (Frova)

Other Acute Medications (check all that apply):

_____ D.H.E _____ Migranal _____ Cafergot _____ Wigraine _____ Bellergal

_____ Midrin _____ Fiorinal _____ Vicoprofen _____ Fioricet _____ Vicodin

_____ Fiorinal w/Codeine _____ Esgic _____ Fioricet w/Codeine _____ Phrenilin

_____ Phrenilin Forte _____ Esgic Plus _____ Tylenol w/Codeine _____ Darvocet N100

_____ Naprosyn

Do you take any of the above medications three (3) or more days per week?

_____ yes, _____ no

Anti-Nausea Medications

_____ Metaclopramide _____ Tigan _____ Compazine _____ Phenergan

Do you take any of the above medications three (3) or more days per week?

_____ yes, _____ no

Rescue Medications:

_____ Stadol Nasal Spray _____ Ultram _____ Morphine _____ Demerol

_____ IV Compazine _____ Toradol _____ Halcion _____ Restoril

_____ Prosom _____ Ambien _____ Dalmane

I use the above medication(s) _____ times a week, _____ times a month

Prophylactic or Daily Medications:

___ Amitriptyline (Elavil) ___ Protriptyline (Vivactyl) ___ Nortriptyline ___ Doxepin
___ SOMA ___ Flexeril ___ Inderal (Propranolol) ___ Tenormin (Atenolol)
___ Toprol ___ Nadolol ___ Timolol ___ Cala (Verapamil) ___ Ergonovine Maleate
___ Clonidine ___ Topamax ___ Neurontin ___ Depakote ___ Serzone ___ Prozac
___ Zoloft ___ Paxil ___ Wellbutrin ___ Atarax ___ Ativan ___ Buspar ___ Effexor
___ Librium ___ Klonopin ___ Xanax ___ Valium ___ Prednisone ___ Lithium
___ Meprobamate

Over the Counter Medications:

___ ASA, Anacin, Bufferin ___ Ibuprofen (Advil, Motrin) ___ Excedrin
___ Acetaminophen (Tylenol) ___ Naproxyn Sodium (Aleve)
I use the above medication(s) ___ times a week,

Nutritional Supplements:

___ B Vitamins ___ Magnesium

Non-Medical/Alternative Treatments

___ Biofeedback ___ Massage ___ Chiropractic ___ Adjustment ___ Yoga
___ Acupuncture ___ Acupressure ___ Rolfing

OTHER HEADACHES:

24. Do you get any other types of headaches? (Please check all that apply)

___ Tension headache ___ Sinus headache ___ Cluster headache ___ Emotional
based headache

25. My Previous Doctors...

- ___ Did not take my headaches seriously.
 - ___ Understood that they are a problem but did not wish to address them.
 - ___ Tried many medications with varying success.
 - ___ Tried many medications with no success and gave up.
 - ___ My case is too difficult for anyone to understand.
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----- **GENERAL HISTORY** -----

HISTORY:

26. Would you say your general health is: ____Excellent ____Good ____Poor

27. Please check any of the following conditions you have had:

- ____Anemia ____Hearing problems ____Asthma ____Heart trouble
- ____Bronchitis ____High blood pressure ____Cancer/tumor ____Kidney/liver disease
- ____Diabetes ____Neuralgia/neuritis ____Epilepsy ____Nervous breakdown
- ____Eye problems ____Pneumonia ____Glaucoma ____Sinusitis ____Hay Fever
- ____Stomach/duodenal ulcer ____Head Injury ____Tuberculosis

28. Please list any medications you are now taking for conditions other than headache - prescription and non-prescriptions drugs

a.Medication:_____ Start Date _____ End date
Reason for discontinuing_____

b.Medication:_____ Start Date _____ End date
Reason for discontinuing_____

c.Medication:_____ Start Date _____ End date
Reason for discontinuing_____

d.Medication:_____ Start Date _____ End date
Reason for discontinuing_____

29. Are you allergic to any medicines?

- | | | |
|-----------------|------------------------|-----------|
| Medication_____ | Allergic reaction_____ | Date_____ |
| Medication_____ | Allergic reaction_____ | Date_____ |
| Medication_____ | Allergic reaction_____ | Date_____ |
| Medication_____ | Allergic reaction_____ | Date_____ |

30. Are you allergic to any of the following foods?

- ____Cheese (any kind) ____Strawberries ____Cola drinks ____Other fruit
- ____Chocolate ____Nuts ____Eggs ____MSG (Mono-sodium Glutamate)(Accent)
- ____Milk ____Spicy foods

31. Have you ever been hospitalized (including pregnancies)? _____ Yes _____ No

If so, please indicate diagnosis...

_____ Date _____

_____ Date _____

_____ Date _____

Were you ever hospitalized due to your headaches? _____ Yes _____ No

32. Do you smoke cigarettes? _____ Yes _____ No If so....

How many years have you smoked? _____ How many packs per day? _____

33. Please answer the following questions by checking each one that is true for you.

Are you bothered a great deal by cold weather?....._____yes _____no

Do your hands or arms ever tremble or shake?....._____yes _____no

Ever short of breath after a little exercise?....._____yes _____no

Ever awake at night short of breath?....._____yes _____no

Do you ever consume alcoholic drinks?....._____yes _____no

If yes, how many drinks on an average _____day _____week _____month _____year

Feel numb or weak on one side of your body?....._____yes _____no

Have you ever fainted?....._____yes _____no

Have you ever had a convulsion?....._____yes _____no

Is your eyesight getting worse?....._____yes _____no

Any problems with your ears or hearing?....._____yes _____no

Ever lost the ability to speak clearly?....._____yes _____no

Ever had varicose veins in your legs?....._____yes _____no

Ever had inflamed veins in your legs?....._____yes _____no

Do you exercise regularly?....._____yes _____no.

Ever use heroin, cocaine or similar drugs?....._____yes _____no

WOMEN ONLY: *How many pregnancies have you had? _____*

How many live births have you had? _____

----- DAILY LIVING PROFILE -----

NEIGHBORHOOD:

34. Neighborhood Concerns (check all which apply)

- My neighborhood is too noisy....._____
- My neighborhood is too crowded....._____
- My neighborhood is too quiet....._____
- I do not have enough friends/neighbors....._____
- It is a dangerous neighborhood in which to live....._____
- Having so many household tasks irritates me....._____
- The weather here bothers me....._____

FAMILY:

35. Family concerns: (check all which apply)

- I am recently married....._____
- I am recently divorced or separated....._____
- I am alone too much at home....._____
- I am concerned about my relationship with my partner (husband/wife)....._____
- I am concerned about my relationship with another family member (parent, child, brother, etc.)....._____
- I or one of my family is having legal problems....._____
- There is serious illness in my family....._____
- I am worried about one of my family members....._____
- Someone in my family drinks too much....._____

WORK:

36. Work concerns: (check all which apply)

- I am bored with the work I do....._____
- Other people make too many demands of me....._____
- I am not satisfied with the work I do....._____
- I have too little control over my own work....._____
- Often I feel overwhelmed by my responsibilities....._____
- There is never enough time to finish my work....._____

PERSONAL:

37. Personal concerns (check all which apply)

- I worry about money a great deal....._____
 - I feel lonely....._____
 - I am bored with my life....._____
 - I am generally concerned about my health....._____
 - I have particular concerns relating to my religion...._____
 - I think a lot about dying....._____
 - I just began a new job....._____
 - I just lost my job....._____
 - I don't get along with my boss....._____
 - I am having problems with people I work with....._____
 - I have difficulty falling asleep....._____
 - I have difficulty staying asleep....._____
 - I have difficulty staying awake....._____
 - I feel tired when I wake up in the morning....._____
 - I feel nervous most of the time....._____
 - I often feel depressed....._____
 - I worry a lot....._____
 - I am ill frequently....._____
 - I have considered committing suicide....._____
 - I have some sexual problems....._____
 - I sometimes feel weak or light-headed....._____
 - I often have pains in my shoulders, neck, or back.._____
 - I often feel like crying....._____
 - I smoke too much....._____
 - I drink too much coffee....._____
 - I often drink too much alcohol....._____
 - I eat more than I used to....._____
 - I eat much less than I used to....._____
 - I am concerned about my weight....._____
 - I lose my temper more than I used to....._____
-