Name:____ Date: ______________________________________

Neurologic & Spine Institute Headache Clinic

Patient History

Name: ______________________________ Male:_____Female:_____Birthdate:____________Age: _______
Address: ______________________________ Phone (Home): ______________________________
______________________________ Phone (Other): ______________________________
Marital Status: ______________________________ Occupation: ______________________________
Employer: ______________________________ Soc. Sec.#: ______________________________
Referred By: ______________________________ Family Physician: ______________________________

Family History

Please Indicate (√) of any blood relatives have severe headaches:

Mother's Side: Father:____Mother:____Aunt:____Uncle:____Grandmother:____Grandfather:___Brother:___Sister____
Father's Side: Father:____Mother:____Aunt:____Uncle:____Grandmother:____Grandfather:___Brother:___Sister____
Please indicate (√) if any blood relatives have had any of the following:
Hearth Disease____Hypertension____Stroke_____Diabetes_____Depression_____Arthritis_____Thyroid Disease_____

General History:

Please indicate (√) if you have had any of the following conditions:

____Diabetes
____Hypertension
____Heart Disease
____Stroke
____Seizures
____Head Injury
____Ear, Nose or Throat Problems
____Arthritis
____Neck/Spine Problems
____Cancer
____Hepatitis/Liver Disease
____Deep Vein Thrombosis
____Thyroid Disease
____Lung Problems
____Stomach Ulcers
____Kidney Disease
____Depression/Anxiety
____Other_________________

Please list any previous surgeries/dates of surgery:

______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________

Allergies:_______Foods_______Medicines_______Dye/Iodine_______Other
Please List:____

Please list current medications, including dosage and frequency (including over-the-counter medications and vitamins):

Medication	Dosage	Frequency	Medication	Dosage	Frequency

I drink____Alcoholic beverages per ____day____week____month.
I drink____Caffeinated beverages per ____day____week____month.
Current drug use:_____Marijuana_____Cocaine/Crack_____Heroin_____Other: ______________________________
I get ____hours of sleep per night. Do you have problems snoring? ____Yes____No
Do you have problems breathign while sleeping? ____Yes ____No
Are you on any special diet? ____Yes ____No Have you have any recent weight loss/gain? ____Yes____No

Name:____ Date: ____

Headache History:

Onset of first headache:
Headaches started _____years ago. I was _____years old.

Cause:
Did you have any accident or injury that may have started your headaches? _____Yes _____No
Do you think something else in your life may have started them? ____

Frequency:
Headaches occur _____times each _________ day ________ week __________ month.
Onset of each headache occures _________ morning ________ afternoon __________ evening _________ night.
Headaches are more frequent in the (check all that apply) _____spring _____summer _____fall _____winter.
Effect of headaches on my ability to function (write in number of days missed per month due to headache):
_________ Work _________ School ________ Social/family activieis
Severity of Headache (scale 1-10): _________ Worse with menses?__________ Yes _________ No

Duration:
Headache lasts _____minutes _____hours _____days with medication.
lasts _____minutes _____hours _____days without medication.

My headaches are often brought on by:

_________ Fatigue
_________ Stress
_________ Oversleeping
_________ Certain Foods
_________ Alcohol
_________ Certain Medications
_________ Hormonal
_________ Coffee
_________ Shaving
_________ Chewing
__________ Talking
__________ Lying down
__________ Stooping
__________ Other ______________________

Location:

_________ Temples
_________ Eye
_________ Front of head
_________ Ear
_________ Around head "hat band"
_________ Neck
_________ Back of head
_________ Jaw
_________ Other_____________

Side of Headache:

_________ Right-side
_________ Left-side
_________ Both sides
_________ Varies

Character:

_________ Throbbing/pulsating
_________ Aching
_________ Tight
_________ Dull
_________ Stabbing
_________ Pressure
_________ Burning
_________ Searing
_________ Shooting
_________ Other_____________

Do you have any warnings/symptoms before headache begins? _________ Yes _________ No

Indicate warnings (check all that apply_

_________ Halos around lights
_________ Blind spot
_________ Blurred vision
_________ Zigzag lines
_________ Vision loss
_________ Double vision
_________ Weakness
_________ Numbness/tingling
_________ Difficulty with speech
_________ Upset stomach
_________ Feelings of tightness
_________ Flashing lights
_________ Dizziness
_________ Lightheadedness

Do you ever experience the above symptoms without headache? _________ Yes _________ No

Name:______________________________ Date: ______________________________

Other assiciated stmptoms with headache (check all that apply)

________	Nausea	________	Ringing in the ears	________	Eye-tearing
________	Vomiting	________	Anxiety	________	Congestion
________	Sensitive to light/sound/odors	________	Irritability	________	Eye-redness
________	Diarrhea	________	Concentration difficulty	________	Drooping eyelid
________	Constipation	________	Memory problems	________	Change in pupil size
________	Increased urination	________	Confusion	________	Fainting
________	Sore/stiff neck	________	Change in appetite	________	Other____________

The following help relieve my headache (check all that apply)

________	Lying down	________	Keeping active	________	Standing
________	Hot compress	________	Dark quiet room	________	Other

Previous Tests (Give date and results)

________	MRI of head________________	________	Labs______________________
________	MRI of neck________________	________	Lumbar Puncture (Spinal Tap)
________	EEG ________________	________	Other______________________
________	Sleep study________________		

Previous Treatments (Give name, date and results of treatment, if known)

________ Primary care provider ______________________________

________ Neurologist ______________________________

________ Chiropractor ______________________________

________ Ophthalmologist ______________________________

________ Psychiatrist/psychologist ______________________________

________ Physical therapist ______________________________

________ Other ______________________________

Previous Headache Medications (Do not include current medications)

Medication	Dosage	Side Effects/Results

Medication	Dosage	Side Effects/Results

☐ Reviewed and discussed above with patient.

Comments: ______________________________

Provider: ______________________________ Date: ______________________________