This New Patient packet is **ONLY** for Headache and Facial Pain patients

PATIENT INFORMATION

Patient Name (Last, First, Maiden)	Date of Birth	Age	Social Security Number

Please provide your referring or regular doctor's full name, address, phone number, and fax number.

Referring Physician or Primary Care Doctor:	
Address:	City, State Zip
Phone:	

HEADACHE HISTORY

1. Onset Of First Headache:

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

2. Precipitating Event (what provoked you first headache):

□None known	□Injury _____		
□Menarche (first period)	□Pregnancy		
□Other: _____			

3. Location of Pain:

□Temples (temporal)	□Eye
□Back of head (occipital)	□Ear
□Side of head (parietal)	□Neck
□Front of head (frontal)	□Jaw
□Around head (holocranial)	□Other:_____

4. Sidedness:

□Right-sided	□Left-sided	□Both Sides	□Varies

5. Changes Sides:

□Between attacks
□During Attacks
□Both between and during

6. Pain Characteristics:

□Throbbing/Pulsing	□Pressure
□Achy	□Burning
□Tight	□Searing
□Dull	□Shooting
□Stabbing	□Other_____

Severity: (How bad is the pain on a scale of 0 to 10: where 0 is no pain and 10 is the worst)

Lowest and highest level of pain for this headache: Low_____ to High _____
Usual severity of this headache type: _____
Worse with menses? _____

Headache disability during or after an attack:

□Normal activity	□Severe decrease in function
□Slight decrease in function	□Confined to bed
□Moderate decrease in function	

7. Duration:

Lasts ___minutes ___hours ___days (with medication) | How often does it recur within 24 hrs?____%
Lasts ___minutes ___hours ___days (without medication) | How often does it recur within 24 hrs?___%
□Headaches are continuous

8. Frequency: (the number of attacks)

____#/day ____#/week ____#/month ____# per year ____# of lifetime attacks ____continuous
Are they increasing in frequency? □Yes □No

(a) How many days in the last month did you experience headaches?
(This includes all days of head or facial pain whether it be mild, moderate, or sever in intensity)
_____days per month

(b) Based on your answer to question (a), how many of these days are your headaches moderate to severe in intensity? (For example, you may experience 20 days of headache per month, of which only 10 are moderate to severe in intensity)
_____days per month

Are you ever HEADACHE FREE? □Yes □No

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

□Heightened feeling of wellness	□Difficulty concentrating	□Increased appetite
□Hyperactive	□Sensitive to light	□Decreased appetite
□Extremely talkative	□Sensitive to sound/noise	□Feeling cold
□Depressed feeling	□Sensitive to odors	□Diarrhea
□Irritability	□Difficulty with speech	□Constipation
□Feeling sluggish	□Excessive yawning	□Extremely thirsty
□Drowsy	□Neck stiffness	□Increased urination
□Restless	□Food cravings	□Fluid retention
□Dizziness	□Weakness	□Other: _____

10. Headache Patterns

Current Pattern:	□Sudden □Rapid □Gradual □Varies
Time of day:	□Morning □Afternoon □Evening □Night □Awakens from sleep □Varies
Are they more frequent:	□Weekends □Weekdays □Vacation □Seasonal □Spring □Summer □Fall □Winter

11. Associated Symptoms:

□Nausea	□Increased urination	□Increased appetite
□Sensitive to:	□Sore/stiff neck	□Decreased appetite
□Light	□Ringing in the ears	□Eye-tearing [Rt Lt Both]
□Sounds	□Blurred vision	□Nose congested [Rt Lt Both]
□Odors	□Anxiety	□Eye-redness [Rt Lt Both]
□Diarrhea	□Irritability	□Drooping eyelid [Rt Lt Both]
□Constipation	□Concentration problems	□Change in pupil [Larger Smaller]
□Insomnia	□Memory problems	□Other:
□Vomiting	□Confusion	□Other:

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

□Blurry vision	□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 headache pain □during headache pain □both before and during
The visual symptoms last a total of: _____.
How long does the aura last before the head pain starts? _____
How long does the aura and head pain last altogether? _____
If you have more than one symptom, do they happen: □One after the other or □All at once?
Do you have a visual aura without headache pain? □Yes □No

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

□Numbness/tingling	□Light headedness	□Unable to speak
[__Right __Left __Both]	□One-sided weakness	□Other:_____
□Dizziness/unsteadiness	□General weakness	□Other:_____
□Vertigo	□Speech difficulty	

Does the sensory aura spread? □Yes-spreads slowly □No-begins all at once
The sensory aura starts: □before headache pain □during headache pain □both before and during
The sensory aura altogether lasts: _____.
How long does the aura last before the 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 or □All at once?
Do you experience sensory aura without headache pain? □Yes □No

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

Food/beverage: □Fasting □Chocolate □Caffeine □Nitrates □MSG
□Alcohol beverages_____ □Wine: [□Red □White] □Other:_____
Physical exertion: □Coughing □Talking □Chewing □Exercise □Sexual intercourse
Hormonal: Menses: □Before □During □After □Pregnancy □Menopause
Stress: □Work □Home □Family □Spouse □Other:_____
Environmental: □Allergies □Weather changes □Altitude □Sunlight □Other:_____
Sleep: □Lack of sleep □Too much sleep □Change in wake/sleep
Other Triggers:_____

15. Activity that worsens headache:

□None	□Climbing steps
□Walking	□Exercise
	□Other: _____

16. Relieving Factors:

□Lying down	□Dark quiet room	□Massage
□Hot compress	□Cold compress	□Pregnancy
□Keeping active/Pacing	□Standing	□Other:_____

Please circle any medications that you <u>have</u> taken for your headache

Advil (ibuprofen)
Aleve
Amerge
Anaprox
Antivert
Arthrotec
Aspirin
Axert
Bellergal
Benadryl
Cafergot
Celebrex
Celexa
Clinoril (sulindac)
Codeine
Compazine
Davocet
Daypro
Decadron
Demerol
DHE
Dilaudid
Duragesic patch
Excedrin
Feldene
Feverfew
Fioricet
Fioricet with codeine
Fiorinal
Fiorinal with codeine
Flexeril
Frova
Haldol
Hydrocodone
Imitrex tabs
Imitrex nasal spray
Imitrex injections
Indocin (indomethacin)
Klonopin (clonazepam)
Lortab
Maxalt
Medrol Dose Pak
Methadone
Methergine
Medrin
Migralief
Migranal
Morphine
Motrin (ibuprofen)
MS Contin
MSIR
Naprelan
Naprosyn
Navane (thiothixene)
Nembutal
Norflex
Norgesic
Nubain
Orudis
Oruvail
Oxy IR/Oxycodone
OxyContin
Parafon Forte
Percocet
Percodan
Phenergan (promethazine)
Phrenilin
Prednisone (prednisolone)
Reglan (metoclopramide)
Relafen (ketoprofen)
Relpax
Robaxin
Skelaxin
Soma
Stadol
Talwin
Thorazine (chlorpromazine)
Tigan
Toradol (ketorolac)
Tylenol
Valium (diazepam)
Vicodin
Vicoprofen
Vioxx
Vistaril
Voltaren (diclofenac)
Wigraine
Xanax (alprazolam)
Zanaflex
Zofran
Zomig
Zyprexa
Other _____

Previous Treatments and testing

□Primary care provider_____

□Neurologist_____

□Otolaryngologist (ENT) _____

□Dentist/dental_____

□Chiropractor_____

□Ophthalmologist_____

□Psychiatrist/psychologist_____

□Biofeedback/relaxation_____

□Physical therapy_____

□Massage_____

□Acupuncture/acupressure_____

□Herbal/homeopathic medicine_____

□Other: _____

Previous Tests (Please give data and results)

□Head MRI

□MRA/MRV

□Cervical MRI

□Lumbar spine MRI

□Head CT

□EEG

□Lumbar puncture

□EKG

□EMG

□Sleep study

□Other:_____

Past Medical History

1. General Health: ☐Excellent ☐Good ☐Fair ☐Poor

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

□Diabetes	□Arthritis	□Ulcers/gastrointestinal problems
□Hypertension	□Cervical neck/spine problem	□Kidney/renal disease
□Heart Disease	□Skin problems	□Infectious disease
□Stroke	□Cancer	Type:_____
□Seizures/epilepsy	Type:_____	□Gynecological problems
□Head injury	□Hepatitis/liver disease	□Psychiatric
□Ear, nose, and throat proble	□Deep vein thrombosis	□Hospitalizations (See Below)
□Dental problems	□Thyroid disease	□Other:_____
□Asthma	□Pulmonary disease	

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

Reason for Hospital Stay	**Date**	**Hospital**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication List

Please list ALL medications currently taken; include over the counter medications (such as Tylenol, advil, Excedrin, etc.), herbs, supplements, and vitamins.

a. In Column "A", please write each medication you use
b. In Column "B", please write the number of milligrams of the medication you take
c. In Column "C", write the number of times you take each medication per day (i.e. 1 pill 2 times/day)

"A" Medication Name	**"B"** Dose in Milligrams	**"C"** # of Time Taken per Day
_____	_____mg	_____
_____	_____mg	_____
_____	_____mg	_____
_____	_____mg	_____
_____	_____mg	_____
_____	_____mg	_____
_____	_____mg	_____
_____	_____mg	_____

Please list ALL allergies

Medication Name	Reaction
_____	_____
_____	_____
_____	_____