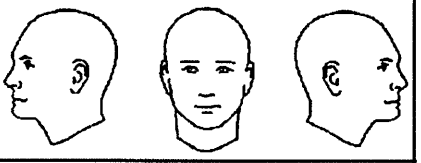
HEADACHE HISTORY

Date _____

Name	**Date of birth**	**Age**
Informant:		
When did the headaches start?		

In what part of the head do your headaches start? (Use diagram also)

____ Left Side	____ Temples
____ Right Side	____ Eyes
____ Both Sides	____ Forehead
____ Back	____ Face
____ Top	____ Neck



Do the headaches interfere with your activities? ___ Yes ___ No
Do the headaches wake you up at night? ___ Yes ___ No
Are the headaches getting?: ___ Worse ___ Better ___ Fluctuates ___ No Change
Are you pregnant? ___ Yes ___ No

How long do the Headaches last?
____ Minutes
____ Hours
____ Days

How often do you have them?
_____ per
____ day ____ Week
____ month

How do the headaches feel?
____ Throbbing
____ Pressure
____ Stabbing
____ Sharp
____ Dull
____ Other
_____
_____
_____

Are any of the following symptoms associated with the headache? R= Right L= Left

General
____ nausea
____ vomiting
____ loss of appetite
____ puffiness
____ slurred speech
____ stomach ache
____ fainting
____ noise sensitivity
____ odor sensitivity
____ runny nose

Ocular
____ double vision
____ visual field loss
____ droopy eyelid (R __ L __)
____ tearing of (R __ L __)
____ redness of (R __ L __)
____ blury vision (R __ L __)
____ light sensitivity
____ spots on vision
____ blindness (R __ L __)
____ dizziness

Mental
____ difficulty concentrating
____ depression
____ fatigue
____ anxiety
____ irritability
____ difficulty talking
____ difficulty understanding

Weakness of
____ face (R __ L __)
____ arm (R __ L __)
____ leg (R __ L __)

Numbness of
____ face (R __ L __)
____ arm (R __ L __)
____ leg (R __ L __)

other _____
_____

What makes your headache better?
☐ rest
☐ activities
____ darkness
☐ quiet environment
☐ heat or cold packs
☐ pressure massage
Other:

What makes your headache worse?
☐ bending
☐ too much sleep
☐ too little sleep
☐ missed meals
☐ weather changes
____ anxiety or nervousness
Other:

☐ alcohol
☐ straining
____ sexual activity
____ physical activity
____ menses

____ foods like:
_____
_____
_____

What medications have you taken for your headaches?	***Response?*** Poor	Fair	Good		***Response?*** Poor	Fair	Good
Tylenol							
Motrin							
Advil							
Excedrin							
Aspirin							

What other medicines do you take?	***who prescribed it?***	***For what?***

Personal History

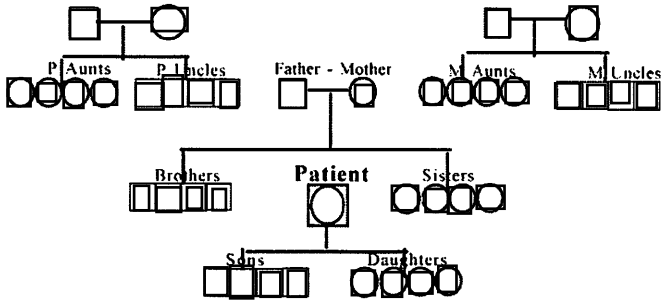
Do you	smoke cigarettes	How many times a day _____ years _____
	consume alcohol	How many ounces _____ day _____
	drink coffe	How many cups _____ day _____

Previous professional treatment of headaches? Yes No - Who & When -

Testing	Y/N	Date	Where	Results
CT Scan				
MRI				
EEG				
X Ray				
Other				

Family History of Headaches

Yes No



Past Medical History

Medical

___ Arthritis
___ Asthma
___ Celiac Disease
___ Crohn's Disease
___ Diabetes
___ Emphysema
___ Gastric ulcers
___ Hypercholesterolemia
___ Hyperlipidemia
___ Hypertension
___ Hypocalcemia
___ Hypothyroidism
___ Lupus
___ Renal failure
___ Rheumatic fever
___ Rheumatoid arthritis

Psychiatric (i.e., emotional problems, depression, stress, drug abuse, alcohol problems, anxiety, behavioral problems)

Neurological

___ Back Injury
___ Head Injury
___ Meningitis
___ Sleep Problems
___ Seizures
___ Fainting Spells

Previous Surgeries:

Past Family History

___ Dementia
Relation:

___ Epilepsy
Relation:

___ Hypertension
Relation:

☐ Headaches
Relation:

___ Mental Retardation
Relation:

___ Gait Difficulty
Relation:

___ Migraines
Relation:

☐ Diabetes
Relation:

___ Blindness
Relation:

___ Neurofibromatosis, Relation: