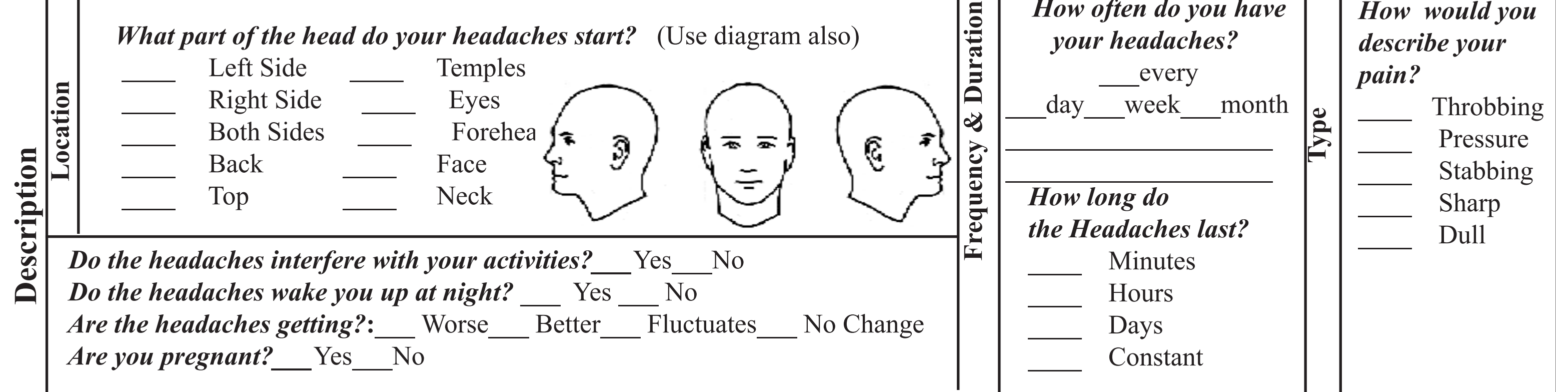
HEADACHE HISTORY

Date

Name	**Date of birth**	**Age**
Informant:		
Symptoms 1.	2.	
Onset	**Allergies:**	

Clinical History

Description



Location

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

____ Left Side ____ Temples
____ Right Side ____ Eyes
____ Both Sides ____ Forehea
____ 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

Frequency & Duration

How often do you have your headaches?
___every
___day___week___month
____
____

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

Type

How would you describe your pain?
____ Throbbing
____ Pressure
____ Stabbing
____ Sharp
____ Dull

Associated Symptoms

Any of the following symptoms associated with the headache? (B) before (✓) during (A) after (X) No

General
____ nausea
____ vomiting
____ loss of appetite
____ puffiness
____ hunger
____ cramps
____ runny nose
____ noise sensitivity
____ odor sensitivity

Ocular
____ double vision
____ half visual field loss
____ eyelid droopiness of (R L B)
____ tearing of (R L B)
____ redness of (R L B)
____ puffiness of (R L B)
____ light sensitivity
____ spots on vision
____ blindness (R L B)
____ blurring (R L B)

Other
____ difficulty concentrating
____ depression
____ fatigue
____ anxiety
____ irritability
____ difficulty talking
____ difficulty understanding
____ lip numbness
____ slurred speech
____ fainting
____ dizziness

Weakness
____ face on (R L)
____ arm on (R L)
____ leg on (R L)

Numbness
____ face on (R L)
____ arm on (R L)
____ leg on (R L)

Improving Factors

What makes your headache better?
____ rest
____ activities
____ darkness
____ quiet environment
____ compresses
____ pressure

Worsening Factors

What makes your headache worse?
____ bending
____ too much sleep
____ too little sleep
____ missed meals
____ weather changes
____ anxiety
____ physical activity
____ processed foods
____ straining
____ sexual activity
____ cheese
____ menses
____ seasonal changes
____ chocolate
____ standing up
____ citrus
____ alcohol
____ contraceptive pills
____ pregnancy

Treatment

What medications have you taken for your headaches?	Response Poor	Fair	Good		Response Poor	Fair	Good		Response Poor	Fair	Good
				Tylenol				Ibuprofen			
				Motrin				Darvocet			
				Advil				Fioricet			
				Exce-				Imitrex			
				Aspirin				Maxalt			

Other Medications

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

Personal History

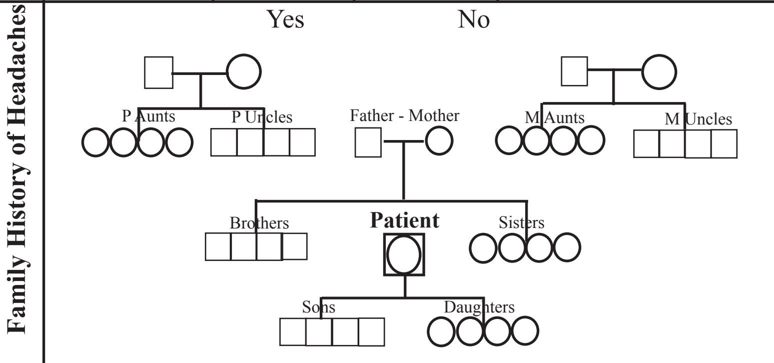
Do you smoke cigarettes — How many times a day _____ years ______
consume alcohol — How many ounces ______ day ______
drink coffe — How many cups _____ day ______

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 Family His-

___ Epilepsy ___ Hypertension

___ Diabetes ___ Neurofibromatosis

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

Neurological

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

Previous Surgeries:

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