Headache History

Headaches have many triggers and I would like to help determine the best treatment course for you, so please provide as much information as possible (even if it doesn't seem important). Please print and complete this form and bring it to your appointment.

What concerns you most about your headaches?

Have you seen a doctor about your headaches in the past? YES / NO When?

Have you ever had a CT scan or MRI to evaluate your headaches? YES / NO (If yes, please list date of last scan and if you have a copy of the report, please bring to your appointment)

At what age do you remember having your first headache?

How often do experience headaches (of any severity)?

Every day 3-5 per week 1-2 per week 1-2 per month 1-2 per year Other:_____

How long do your average headaches last?

<30 minutes 1-2 hours 3-6 hours All day 2-3 days Other: _____

On a scale of 1-10 (10 is the worse pain imaginable, 1 is barely noticeable):
How severe are your average headaches?
How severe are your worst headaches?
How often do the severe headaches occur?

Where do you experience your headache pain? (circle all that apply) Forehead Around/behind eyes

Temples Right side of head Left side of head Base of skull Neck Whole Head

What type of pain do you have? Dull Aching Sharp Throbbing Pulsing

Knife-like stabbing Electrical shock Searing/Tearing

Please circle any of the following symptoms that you have had before, during or after a headache:

Nausea Vomiting Light sensitivity Sound sensitivity Dizziness Light-headedness

Sinus pressure Runny nose Watery eye (Right/left or both?) Blurry vision Flashing lights

Tingling (where?) Numbness (where?) Other:

Have you identified anything that triggers your headaches?

How much caffeine do you drink per day? _____ ounces of : COFFEE / TEA / SODA
How many hours of sleep do you get each night?
Is your sleep schedule: CONSISTENT / VARIABLE
How often do you take decongestants (Sudafed, phenylephrine)? _____days per WEEK / MONTH

Exercise: _____ days per WEEK / MONTH What type of exercise:
Do you ever experience a headache during exercise? YES / NO

Do you drink alcohol? YES / NO If yes, how many drinks per week? What type?
Do you smoke? YES / NO

Do any family members have any of the following conditions? Stroke Brain aneurysm Brain tumor

When you get a headache, do you take medication? YES / NO

When you first notice the headache, do you take medication: Immediately Within 30 minutes
Within 1 hour More than 1 hour Wait until it gets severe

How many days per week do you take ANY medication for your headaches?

If you have currently take medication or have tried any of these in the past, please mark the medication you tried and make any notes about its efficacy, side effects, etc.
Over-the-counter:
___ Ibuprofen (Advil, Motrin) How many tablets at a time? How often?
___ Naproxen (Aleve) How many tablets at a time? How often?
___Excedrin How many tablets at a time? How often?
___ Tylenol (acetaminophen) How many tablets at a time? How often?

Prescriptions:
___ Imitrex (sumatriptan) tab/nasal spray/injection
___ Maxalt (rizatriptan) tab/dissolving tab
___ Relpax
___ Axert (almotriptan)
___ Zomig tab/dissolving tab/nasal spray
___ Treximet
___ Amerge
___ Midrin
___ Migranal (DHE)

Daily Preventatives:

___ Topamax (topiramate)

___ Inderal (propranolol)

___ Verapamil

___ Elavil (amitriptyline)

___ Pamelor (nortriptyline)

___ Depakote

___ Neurontin (gabapentin)

___ Zonegran (zonisamide)

___ Other:

Supplements:

___ Magnesium Dose? Type?

___ Butterbur (Petadolex or another brand?)

___ Riboflavin

___ Co Q10

___ Feverfew

___ Other:

Women:
Are you on birth control? YES/NO If yes, what brand?
Are your periods REGULAR/IRREGULAR
Do you have headaches around your menstrual cycle? YES/NO
If yes, when do they occur? Before Beginning End During entire cycle

If you have time prior to your appointment, please keep a log of all food and drink consumed for 3-5 days (this is most helpful if you are eating your typical diet), the time of day it was consumed, and if you have a headache.