PROVIDENCE
St. Mary
Neuroscience Institute

Headache and Health History Questionnaire

Name:_____Today's Date:_____

Date of Birth:_____ Age:_____ Height:_____ Weight:_____

PCP:_____ Referring Provider?_____

Why are you seeing the doctor today?_____

_____

Please list any major complaint(s) and describe their onset (i.e., lower back began in May 2012 after lifting):

_____

_____

_____

Are you having any? □ Numbness Where?_____

□ Weakness Where?_____

Is this visit related to an injury? □Yes □No On the job? □Yes □No

If so, date of injury: _____ Date of last employment:_____

Do you have any open worker's compensation claims of any kind? □Yes □No

Do you have a lawsuit pending? □Yes □No

Please circle the description which applies to your intensity of pain: Stable, unchanged, gradually worsening, rapidly

Worsening, gradually improving, rapidly improving, completely resolved.

What started the pain/problem?_____

_____

Previous physicians seen for this problem?

Physician	Specialty	City	Treatment

Onset of headache:

□ Recently started (dates) _____

□ Since childhood (dates) _____

□ Since the age of _____years old

□ For about the last _____days/weeks/months/years

□ Following head injury, trauma, or motor vehicle accident which occurred on (date)_____

Location of headache:

□ Frontal (forehead) □ Parietal (side of head) □ Band-like (surrounding head)

□ Occipital (neck) □ Temple □ Orbital (around the eyes) □ Retro-orbital (behind the eyes)

Does headache occur on?

□ One side (right or left) □ Radiates from neck to forehead □ Both sides

□ Involves entire head □ Shifts from side to side □ Other _____

Do you feel you have more than one type of headache: □ Yes □ No

If yes, _____

_____

_____

Frequency of headaches:

□ Daily □ Almost daily □ Intermittent throughout the day

□ Approximately how many times _____per day/week/month/year (circle one)

Severity of head:

□ Mild □ Is the headache aggravated with bending over, walking, climbing stairs, or activity

□ Mild to moderate □ Do you have to lie down in a quiet dark room on occasions?

□ Moderate □ Lying down makes headache worse?

□ Moderate-severe □ Do you ever miss work/school because of headache?

□ Severe

Duration of headache:

□ Constant in nature

□ Last approximately _____ minutes/hours/days

□ Goes away in _____minutes/hours if treated immediately with (name of medication) _____

Timing of headache:

□ Starts mild and progress to severe within _____minutes/hours/days(circle one)

□ Severe at onset

Quality of headache: How would you best describe your headaches?

Please mark all that apply.

□ Band-like □ Sharp □ Dull achiness

□ Stabbing □ Constant headache □ Squeezing

□ Piercing □ throbbing □ Pinching

□ Vice-like □ Pounding □ Pressure

□ Pulsating □ Feels like head is going to explode

□ Feels like someone is squeezing your head □ Other_____

Situation: Do the headaches awaken you from sleep? □Yes □ No

If yes, any special time after falling asleep:_____

_____

_____

Prodrome: Do you notice any of the following symptoms 1-3 days prior to the onset of the headache?

□ Mood changes such as anxiety or depression □ Fatigue

□ Food craving □ Increased urination

□ Increased thirst □ Cervical stiffness or pain

□ Loss of appetite □ Other_____

Aura: Do you have vision changes that occur within 1 hour to the onset of the headache? □ Yes □No

If yes, do you see?

□ Spots □ Partial visual field loss □ Visual blurring

□ Illusions of distorted size/shape □ Simmering or wavy lines

□ Facial or upper extremity numbness and/or tingling □ Zig zag patterns

□ Flashes of light

Symptoms: Which symptoms accompany your headache?

□ None □ Nausea □ Lightheadedness/dizziness

□ Vomiting □ Slurred speech □ Difficulty with memory/concentration

□ Pacing □ Tenderness to temples □ Hair and/or scalp ache

□ Jaw tightness □ Nasal congestion □ Muscle achiness

□ Fever □ Diarrhea □ Neck tightness/stiffness

□ Tearing/watering of the eye on the affected side of the head

□ Sensitive to sound/noise (sonophobia) □ Sensitive to light/brightness (photophobia)

□ Vision problems (please explain)_____

Headache precipitating factors/triggers: Do any of the following tend to bring on a headache?

A. Physical triggers

□ Brushing teeth
□ Coughing
□ Eating/chewing/speaking
□ Exposure to glare
□ Flickering lights
□ Fluorescent lights
□ Prolonged neck movement
□ Loud noises
□ Menstrual cycle
□ Physical activity
□ Sexual activity
□ Too much sleep
□ Too little sleep
□ Cigarette/cigar smoke
□ Other: _____

B. Food/Drink triggers

□ Alcohol
□ Bananas
□ Caffeine
□ Cheese
□ Chocolate
□ Citrus fruit
□ Monosodium glutamate (MSG)
□ Nuts

Headache precipitating factors/triggers: Do any of the following tend to bring on a headache?

C. Psychological Triggers

□ Family illness
□ Personal illness
□ Financial difficulties
□ Stress/tension
□ Marital status
□ Other_____

D. Seasonal/Allergy

□ Allergies to _____
□ Exposure to cold/hot weather
□ High altitude
□ High humidity
□ Other _____
□ Scented candles
□ Weather changes (rain/thunderstorms/etc)
□ Food odors
□ Perfume

E. Occupation/work triggers

□ Chemical fumes (gas, oil, kerosene)
□ Chemical odor
□ Repetitive movements
□ Other _____
□ Prolonged computer usage
□ Employment security (fear of being fired, lay-off
□ Work relationships/conflict

Headache medication used in the past to alleviate the pain:

□ None
□ Butabitol
□ Cafergot
□ Esgic Plus
□ Fioricet
□ Fiorinal
□ Phrenilin
□ Phrenilin Forte
□ Midrin
□ Stadol Nasal Spray
□ Axert
□ Amerge
□ Eletriptan (relpax)
□ Frovatriptan
□ Imitrex tablets
□ Imitrex nasal spray
□ Imitrex injection
□ Maxalt oral tablet
□ Maxalt melt tablets (MLT)
□ Migranal nasal spray
□ Zomig oral tablets
□ Zomig melt tablets (ZMT)
□ Zomig Nasal Spray
□ Dihydroergotamine (DHE)

Did you ever take any medications on a daily basis to prevent or decrease the frequency/occurrence of headache?

□ Yes □ No If yes, please check all the daily medications taken in the past to prevent headaches.

Anticonvulsants

□ Depakote (ER)
□ Keppra
□ Neurontin
□ Topamax
□ Trileptal
□ Lamictal
□ Lyrica
□ Tegretol (XR)
□ Zonegran

Antidepressants

□ Celexa
□ Cymbalta
□ Effexor (XR)
□ Elavil (Amitriptyline)
□ Lexapro
□ Nortriptyline
□ Paxil (CR)
□ Prozac
□ Zoloft
□Wellbutrin (XL, SR)

Antiemetics

□ Compazine
□ Phenergan
□ Reglan
□ Tigan
□ Vistaril

Antihypertensives

□ Atenolol (Tenormin)
□ Corgard
□ Inderal (Propranolol)
□ Verapamil/Calan (SR)
□ Lopressor/Metoprolol/ Toprol XL

Anti-Inflammatory

□ Advil
□ Aleve
□ Anaprox (Naprosyn)
□ Bextra
□ Celebrex
□ Clinoril
□ Daypro

Narcotic Analgesic

□ Darvocet/Darvon
□ Demerol
□ Dilaudid
□ Morphine
□ Percocet/Percodan
□ Tylenol 2,3, & 4
□ Vicodin

Over the Counter

□ Advil Migraine
□ Excedrine
□ Excedrine Migraine
□ Ibuprofen Migraine
□ Tylenol
□ Other_____

Muscle Relaxants

□ Flexeril
□ Robaxin
□ Skelaxin
□ Soma
□ Zanaflex

……..Continued Anti-Inflammatory medication

□ Disalcid (Salsalate)

□ Diclofenac (Voltaren)

□ Feldene

□ Indocin

□ Medrol dose pack

□ Motrin (Ibuprofen)

□ Mobic

□ Prednisone

□ Ultram

□ Relafen

□ Vioxx

PAST MEDICAL HISTORY: Check all that apply □ None Apply

□ Abnormal heartbeat	□ Cirrhosis	□ High blood pressure	Neuropathy: □ Hands □ Feet
□ ADHD	□ Depression	□ High cholesterol	□ Poor circulation
□ Anemia	□ Down syndrome	□ HIV/AIDS	□ Seizure
□ Anxiety	□ Emphysema	□ Kidney failure	□ Spina bifida
□ Asthma	□ Gastric reflux	□ Kidney stones	□ Stomach ulcers
□ Bleeding disorder	□ Gout	□ Migraine	□ Stroke
□ Blood clots in leg	□ Heart attack	□ Multiple Sclerosis (MS)	□ Thyroid
□ Blood clots in lung	□ Heart failure	□ Neurofibromatosis	□ Tuberculosis
□ Cerebral palsy	□ Hepatitis B or C	□ Osteoporosis	□ Fibromyalgia
□ Osteoarthritis	□ Rheumatoid arthritis	□ Other Rheumatological Disease	

Cancer:_____(type and treatment)

□ Diabetes: If yes, when was it diagnosed?_____

Currently controlled with: □ Insulin □ Oral medication □ Diet

Other:_____

PAST SURGICAL HISTORY: □ No prior surgery

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia? □ Yes □ No

If yes, have you had any problems related to this? □ Yes □ No

Explain any problems with general anesthesia:_____

Social History: Work status

□ Working □ Homemaker □ Unemployed □ Disabled □ On leave □ Retired □ Student

Occupation: _____

Education: _____

Marital status: □ Single □ Married □ Divorced □ Widowed

Children: □ No □ Yes, how many? _____

Do you live alone? □ Yes □ No If no, who lives with you?_____

Are you currently smoking? □ Yes □ No If yes, how many pack/day? _____For how many years? _____

Have you previously quit smoking? If so, when did you quit? _____How many years did you smoke? _____

How many packs a day did you previously smoke? _____Other forms of tobacco used? _____

Alcohol use: □ Never □ Rare □ Social □ Frequently (more than twice a week)
□ Alcoholic □ Recovering alcoholic

Illegal drug use: □ Never □ In the past □ Currently □ Types of drugs? _____

Do you drink caffeine? □ Yes □ No How much? _____

Sexually active: □ Yes □ No

FAMILY HISTORY: Please fill in the illness information below with the options listed:

Alcoholism	Cancer	High blood pressure	Other Rheumatological Disease
Arthritis	Diabetes	Kidney problems	Seizure
Bleeding problems	Gout	Lung problems	Stroke
Blood clots	Heart problems	Mental Illness	Other

FAMILY MEMBER	ILLNESS	AGE	IF DECEASED, AGE AT DEATH AND CAUSE
Father			
Mother			
Brother(s)			
Sisters			
Children			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Paternal Uncle			
Paternal Aunt			
Maternal Uncle			
Maternal Aunt			

Family History Unknown □ Adopted □

Please rate your usual level of pain on the following scale (circle one):

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst imaginable pain)

Patient's signature: _____

Provider signature: _____

Date: _____

Date: _____