BlueSky
NEUROLOGY

# Head Pain Intake Form

Your evaluation will take one hour to complete and in order to best utilize the time, please take the time to complete this questionnaire prior to your appointment. **Please answer ALL of the questions on this form.** Your careful attention to detail is very important because it allows it allows the physician to design the most appropriate type of evaluation and treatment program especially for you and your specific problem.

**Name:** ______________________________ **Date:** ______________

## Headache History/Description

My primary headache problem started ____________ years ago.

Did you have an accident that may have started your headaches? ___ Yes ___ No

Do you believe that some other event in your life started your headaches? ___ Yes ___ No

If yes, please explain: ______________________________

______________________________

What is your goal for coming to Blue Sky Neurology? ______________________________

______________________________

Prior headache history: ______________________________

Family history of head pain? ___ Yes ___ No

If yes, check the following who have head pain in your family: ___ Parent ___ Sibling ___ Child

Do you have more than one type of headache? ___ Yes ___ No

How many days per month do you have headache? Least/per month: _____ Most/per month: _____

Is it increasing in frequency? ___ Yes ___ No

Is it increasing in duration? ___ Yes ___ No

Is it increasing in severity? ___ Yes ___ No

How would you describe your pain?: ___ Throbbing/Pulsating ___ Sharp ___ Pressing/Squeezing

___ Dull/Nagging ___ Tight Band ___ Stabbing ___ Other (Describe): ______________

Where is your pain? ___ One Side ___ Both Sides ___ Whole Head

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# Head Pain Intake Form Continued

## Headache Symptoms *(Please check **all** of your symptoms at the time of your headaches)*:

**Gastrointestinal**

__ Decreased Appetite
__ Nausea
__ Vomiting
__ Diarrhea
__ Constipation

**Sensory**

__ Scalp Tenderness
__ Tingling
__ Numbness
__ Ringing in Ears
__ Noise Sensitivity
__ Odor Sensitivity

**Vasomotor**

__ Chills
__ Flushing
__ Stuffy Nose (R / L)
__ Runny Nose (R / L)
__ Cold Hands/Feet
__ Pale or Bluish Hands/Feet
__ Eyes Watering (R / L)

**Visual**

__ Light Sensitivity
__ Blurred Vision
__ Double Vision
__ Spots (in Front of Eyes)
__ Zigzag Line
__ Bright Spots
__ Blind Spots
__ Colors
__ Eyelid Droop (R / L)

**Mental**

__ Poor Concentration
__ Memory Difficulties
__ Confusion

**Vestibular**

__ Dizzy/Unsteady
__ Sensation of Movement
__ Fainting

**Motor**

__ Trouble Speaking (saying right words)
__ Trouble with Balance
__ Trouble Moving (extremities)

**Emotional**

__ Depressed
__ Irritable
__ Restless
__ Anxious or Nervous
__ Frustrated

**General**

__ No Energy (Lethargic)
__ Fatigue
__ Neck Pain
__ Back Pain
__ Aura
__ Other: ___________

## Headache Triggers *(Please check all of the following that you feel may "trigger" or start your severe headache)*:

__ Alcohol
__ Food
__ Altitude
__ Menses
__ Fasting
__ Sex
__ Emotions
__ Weather
__ Lack of Sleep
__ Orgasm
__ Stress
__ Sun
__ Too Much Sleep
__ Exertion
__ Allergies/Sinus
__ Bright Light
__ Weekends
__ Medication
__ Odors
__ Vacations
__ Seasonal
__ Let Down

## Headache Durations

How long does your headache usually last? Shortest: ____________________ Longest: ____________________

Is it constant? ________________________________________________________________

Since this headache began, what has been the longest **headache free** period?

________________________ Hours/Days ___________________________ Days/Weeks

## *** FOR WOMEN ONLY ***

__ Menstrual Period
__ Menopause
__ Ovulation
__ Contraceptives
__ Time Before Menstruation
__ Other Hormone Therapy
__ Pregnancy

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# Head Pain Intake Form Continued

## General Headache Information *(Please list for the past week)*:

___ Number of ***mild*** headaches ___ Number of ***moderate*** headaches ___ Number of ***severe*** headaches

My headache usually starts: ___During the night ___During the day ___Upon awakening ___Unpredictable

Time missed from work: (please circle) _____ days _____ weeks _____ months

How many emergency room visits have you made from headache? (please circle)

____ per week / month / year

How dysfunctional are you because of headache? _____ Mild _____ Moderate _____ Severe

### Sleep

___ I have difficulty falling asleep

___ I need medication(s) to fall asleep Please list: ______________________________

___ Headache awakens me from sleep How many times per night, if at all? ______________

___ I have difficulty staying asleep for reasons **other** than headache

___ I awaken earlier than usual

Other things I do to help me sleep: ______________________________

### Personal Habits

Caffeine: _____ cups of coffee/day ____ cups of tea/day _____ 12 oz cans of soft drinks/day

Tobacco: _____ cigarettes _____ packs/day _____ I am trying to quit tobacco use

Other Substances: _____ alcohol – amount per day _______ _____ marijuana _____ cocaine

Other recreational drugs: ______________________________

___ I get some form of exercise on a regular basis. If so, list type and frequency: ______________

### Diagnostic Imaging History

What diagnostic tests have you had relating to your headaches?

___ Neurological examinations How many? _____ _____ CT- Head & Neck _____ How many? ____

___ EEG How many? _____ _____ MRI- Head & Neck _____ How many? ____

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# Head Pain Intake Form Continued

## Past Medical History *(Please circle all applicable)*

**Do you or have you ever had any problems with the following:**

| | | | Explanation: |
|---|---|---|---|
| Hypertension | Yes | No | |
| Diabetes | Yes | No | |
| Heart | Yes | No | |
| Stomach Pain | Yes | No | |
| Ulcers | Yes | No | |
| Liver | Yes | No | |
| Thyroid | Yes | No | |
| Unexplained Fevers | Yes | No | |
| Sweats | Yes | No | |
| Chills | Yes | No | |
| Loss of Appetite | Yes | No | |
| Weight Loss | | | |
| More than 10 lbs. | Yes | No | |
| Difficulty Sleeping | Yes | No | |
| Sexual Functions | Yes | No | |
| Chronic Tiredness | Yes | No | |
| Circulation | Yes | No | |
| Coughing Up Blood | Yes | No | |
| Chest Pain | Yes | No | |
| Swollen Ankles | Yes | No | |
| Difficulty Urinating | Yes | No | |
| Blood in Urine | Yes | No | |
| Stiff or Swollen Joints | Yes | No | |
| Easy Bruising or Bleeding | Yes | No | |
| Dizziness | Yes | No | |
| Fainting | Yes | No | |
| Depression | Yes | No | |
| Nerves/Anxiety | Yes | No | |
| Bowel Problems: | | | |
| Constipation | Yes | No | |
| Diarrhea | Yes | No | |
| Incontinence | Yes | No | |
| Bladder Problems: | | | |
| Retention | Yes | No | |
| Frequency | Yes | No | |
| Incontinence | Yes | No | |
| History of Motion Sickness | Yes | No | |
| History of Head Trauma | Yes | No | |
| History of Cold Hands/Feet | Yes | No | |

Family History: ______________________________

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# Head Pain Intake Form Continued

**Medications** *Please list any medications you are allergic to:*

(1) ____________________ (2) ________________________ (3) ______________________ (4) _____________________

*Please check each medication you have used for headache or other reasons:*

**Anti-Inflammatories**

__ Orudis __ Naprosyn __ Anaprox __Motrin __ Ibuprofen __ Advil __ Aleve __ Indocin
__ DayPro __ Cataflam __ Voltaren __ Lodine __ Relafen __ Toradol __ Celebrex

**Antidepressants**

__ Elavil __ Pamelor __ Prozac __ Zoloft __ Paxil __ Effexor __ Welbutrin __ Zyprexa
__ Celexa __ Abilify __ Lexapro __ Prestiq __ Cymbalta

**Antimigraine Medications**

__ Methergine __ Sansert __ DHE __ Frova __ Midrin __ Imitrex __ Maxalt __ Zomig
__ Amerge __ Migranal __ Treximet __ Sumavel __ Relpax __ Axert

**Antinausea/Phenothiazines**

__ Phenergan __ Compazine __ Tigan __ Reglan

**Decongestants/Antihistamines**

__ Benadryl __ Vistaril __ Antivert __ Periactin

**Heart/Blood Pressure**

__ Cardene __ Veralan __ Verapamil __ Corgard __Lopressor __ Tenormin __ Inderal __Propranolol
__ Timolol __ Lisinopril

**Neuromodulators**

__ Topamax __ Depakote __ Lyrica __ Keppra __ Neurontin

**Sleeping Pills/Tranquilizers**

__ Ambien __ Lunesta __ Xanax __ Ativan __ BuSpar __ Halcion __ Dalmane __ Restoril
__ Klonopin

**Steroids**

__ Prednisone __ Hydrocortisone __ Decadron __ Medrol

**Alternatives**

__ Petodolex __ Magnesium __ CoQ __ Vitamin B __ Vitamin D3 __ Botox

**Other**

__ Vimpat __ Aricept __ Namenda

*List any other medication(s) that you use for headache that does not appear on the above list:*

(1) ____________________ (2) _______________________ (3) ______________________ (4) ____________________

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# Head Pain Intake Form Continued

## Medications

Please list all medications you are taking or have taken (including over-the-counter medications such as Tylenol, birth control pills, hormones, cold and sinus medication, etc.); being very specific. Follow the example below and indicate the **actual number of times and number of days of the week** you are taking the medication, even if it is not on a daily basis. ***PLEASE DO NOT USE "PRN", "AS NEEDED".***

**EXAMPLE:**

| Name of Medication | Dose/Strength | No. Times/Day | No. Days/Week | How Long Taken? |
|---|---|---|---|---|
| Tylenol ES | 2 – 500 mg. tabs | 1 time/day | 3 days/week | 6 months |

**CURRENT MEDICATION LIST**

| | | | | |
|---|---|---|---|---|
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