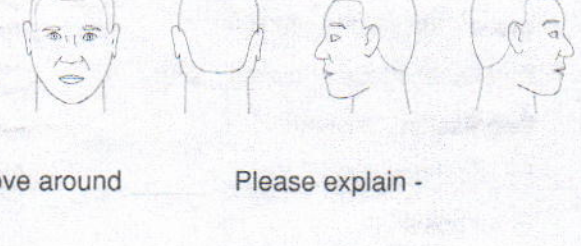
HEADACHE HISTORY & PROFILE

Formedic

NAME DATE OF BIRTH DATE

On what part of the head do the headaches start? Use diagrams to indicate -



___ (R) Side ___ (L) Side ___ Either side ___ Both sides

___ Back ___ On top ___ Temples ___ Behind / around eyes

___ Forehead ___ Face ___ Neck ___ Other -

After the headache starts – Does it usually – Stay in one place ___ Move around ___ Please explain -

How would you describe the pain? - ___ Throbbing / pulsating ___ Pressing / squeezing ___ Stabbing ___ Sharp

___ Dull / nagging ___ Other -

Describe the degree of pain (circle one #) - slight - 1 2 3 4 5 6 7 8 9 10 - worst imaginable

Do your headaches interfere or prevent normal activities - work etc.? ❑ No ❑ Yes

How long ago did the current headaches start? ___ Weeks ___ Months ___ Years

How old were you when any headache started? ___

How long does the headache usually last? ___ Minutes ___ Hours ___ Days ___ Constant

How often does the headache occur? ___ x / Day ___ x / Week ___ x / Month ___ x / Year ___ Constant

Does the headache awaken you from sleep? ❑ Yes ❑ No

Is the headache getting ___ worse ___ better ___ fluctuating ___ no change

Are any of the following symptoms associated with the headache? Please mark (B) before (✓) during (A) after

___ Spots before eyes - type -

___ Blindness (R L)

___ Blurring (R L)

___ Double vision

___ Can see only half of objects

___ Eyelid droop (R L)

___ Tearing (R L)

___ Eye redness (R L)

___ Eyes puffy (R L)

___ Light sensitivity

___ Noise sensitivity

___ Odors sensitivity

___ Nose blocked / discharge (R L)

___ Nausea ___ Vomiting

___ Loss of appetite ___ Hunger

___ Cramps ___ Diarrhea

Face - Scalp -

___ Pale ___ Redness

___ Sweating ___ Tender

___ Puffy ___ Pain on chewing

___ Decreased jaw opening

Neck -

___ Stiff ___ Tender

___ Difficulty concentrating

___ Depression ___ Anxiety

___ Fatigue ___ Irritability

Weakness(W) Numbness(N) Both(B)

___ Face (R L) ___ Arms (R L)

___ Arm & leg (R L) ___ Legs (R L)

___ Difficulty talking (finding words)

___ Difficulty understanding

___ Numbness around lips

___ Slurred speech

___ Fainting (feel like or have fainted)

___ Dizzy (lightheaded - unsteady - spinning)

Hands and / or feet -

___ Cold ___ Pale

___ Sweaty ___ Mottled

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over →

HEADACHE HISTORY & PROFILE (continued)

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Indicate if any of the following factors have (✓) brought on (trigger) or (x) worsen your headache –

___ Head injury	___ Sexual activity	___ Other foods ___
___ Sleep - too much - too little	___ Missed meal	
___ Emotional stress ___ during ___ after	___ Change in weather	
___ Depression - anxiety	___ Seasons -	___ Medications ___
___ Physical activity	___ Alcohol ___ MSG	
___ Erect position	___ Processed meats	___ Menstrual periods
___ Bending over	___ Chocolate ___ Citrus fruits	___ Pregnancy ___ Menopause
___ Straining - coughing	___ Cheeses	___ Contraceptives

Do any blood relatives have severe headaches? ❑ No ❑ Yes – Who & Diagnosis –

Which of the following makes the headache better? ___ Rest ___ Activity ___ Darkness ___ Quiet ___ Compresses ___ Scalp or temple pressure ___ Pregnancy ___ Menopause

Social history - Cigarettes (#day / #yrs.) Alcohol (oz. / day) Coffee (cups / day)

Are you or have you been - ___ Depressed ___ Anxious

Previous professional treatment of headache? ❑ No ❑ Yes – Who & When –

Previous x-ray or other investigations of headache? ❑ No ❑ Yes – Describe –

Previous medications for headache? ❑ No ❑ Yes Name – dosage

Other current medications? Please list – include over the counter drugs

DRUG ALLERGIES

ADDITIONAL NOTES

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