Montefiore

Date:_____

Montefiore Headache Center

Patient History

Name _____ Date of Birth_____ Age_____ ☐ M ☐ F
Address _____ Birthplace_____
_____ Zip Code_____
Phone (Home) _____ (Work)_____ (Cell)_____

Marital Status ☐S ☐M ☐W ☐Div ☐Sep

Referred by: ☐primary care physician ☐other neurologist ☐family member ☐friend ☐other_____

Please provide your referring or regular doctor's full name, address, phone number, and fax number. All of this information is required in order to mail or fax a letter to your doctor.

Referring Physician or Primary Care Doctor:_____
Address:_____
_____
Phone:_____ Fax:_____

Pharmacy Phone Number:_____

ALLERGIES TO MEDICATION: _____

Are you interested in participating in any clinical trials: ☐ YES ☐ NO

Headache History

1. **Onset Of First Headache:**
   Headaches started ____ years ago. I was: _____ years old.

2. **Precipitating Event** (what provoked you first headache):
   ☐None known ☐Injury_____
   ☐Menarche (first period) ☐Pregnancy
   ☐Other:_____

3. **Location of Pain:**
   ☐Temples (temporal) ☐Eye
   ☐Back of head (occipital) ☐Ear
   ☐Side of head (parietal) ☐Neck
   ☐Front of head (frontal) ☐Jaw
   ☐Around head (holocranial) ☐Other:_____

4. **Sidedness:**
☐Right-sided
☐Left-sided
☐Both Sides ☐Varies

Changes Sides:
☐Between attacks
☐During Attacks
☐Both between and during

5. **Pain Characteristics:**
☐Throbbing/Pulsing
☐Achy
☐Tight
☐Dull
☐Stabbing
☐Pressure
☐Burning
☐Searing
☐Shooting
☐Other_____

6. **Severity:** (How bad is the pain on a scale of 0 to 10: where 0 is no pain and 10 is the worst)
Lowest and highest level of pain for this headache: Low_____ to High _____
Usual severity of this headache type: _____
Worse with menses? ☐Yes ☐No

Headache disability during or after an attack:
☐Normal activity
☐Slight decrease in function
☐Moderate decrease in function
☐Severe decrease in function
☐Confined to bed

7. **Duration: (How long do they last?)**
Lasts ___minutes ___hours ___days (with medication) | How often does it recur within 24 hrs?____%
Lasts ___minutes ___hours ___days (without medication) | How often does it recur within 24 hrs?___%
☐Headaches are continuous

8. **Frequency: (the number of attacks)**
____#/day ____#/week ____#/month ____# per year ____# of lifetime attacks ____continuous
Are they increasing in frequency? ☐Yes ☐No

(a) How many days in the last month did you experience headaches? (This includes all days of head or facial pain whether it be mild, moderate, or sever in intensity)
_____**days per month**

(b) Based on your answer to question (a), how many of these days are your headaches moderate to severe in intensity? (For example, you may experience **20** days of headache per month, of which only **10** are moderate to severe in intensity)
_____**days per month**

(c) Are you ever HEADACHE FREE? ☐Yes ☐No

☐Pregnancy ☐Vacation ☐Weekends ☐Random ☐Remission ☐Other_____

9. **Premonitory Symptoms** (you experience one or more of these symptoms before onset of headache):

☐Heightened feeling of wellness
☐Hyperactive
☐Extremely talkative
☐Depressed feeling
☐Irritability
☐Drowsy
☐Restless
☐Dizziness
☐Difficulty concentrating
☐Sensitive to light
☐Sensitive to sound/noise
☐Sensitive to odors
☐Difficulty with speech
☐Excessive yawning
☐Neck stiffness
☐Food cravings
☐Weakness
☐Increased appetite
☐Decreased appetite
☐Feeling cold
☐Diarrhea
☐Constipation
☐Extremely thirsty

10. **Current Pattern:** ☐Sudden ☐Rapid ☐Gradual ☐Varies

Time of day: ☐Morning ☐Afternoon ☐Evening ☐Night ☐ Sleeping ☐Varies

Are they more frequent: ☐Weekends ☐Weekdays ☐Vacation ☐Seasonal

11. **Associated Symptoms:**

☐Nausea
☐Vomiting
☐Sensitive to:
  ☐Light
  ☐Sounds
  ☐Odors
☐Diarrhea
☐Insomnia
☐Sore/stiff neck
☐Ringing in the ears
☐Blurred vision
☐Anxiety
☐Irritability
☐Concentration problems
☐Memory problems
☐Confusion
☐Increased appetite
☐Decreased appetite
☐Eye-tearing [Rt Lt Both]
☐Nose congested [Rt Lt Both]
☐Eye-redness [Rt Lt Both]
☐Drooping eyelid [Rt Lt Both]
☐Change in pupil [Larger Smaller]
☐Other:_____
☐Other:_____

12. **Aura: Visual (Do you have these symptoms before your headache begins?)**

☐Flashing lights
☐Zigzag lines
☐Loss of vision in one eye
☐Loss of vision on one side
☐Total blindness
☐Tunnel vision
☐Double vision
☐Other:_____

The visual symptoms start: ☐before headache pain ☐during headache pain ☐both before and during
The visual symptoms last a total of: _____
Do you have a visual aura without headache pain? ☐Yes ☐No

13. **Aura: Sensory**

☐Numbness/tingling [__Right __Left __Both]
☐Dizziness/unsteadiness
☐Vertigo
☐Light headedness
☐One-sided weakness
☐General weakness
☐Speech difficulty
☐Unable to speak

The sensory aura starts: ☐before headache pain ☐during headache pain ☐both before and during
The sensory aura altogether lasts: _____.
Do you experience sensory aura without headache pain? ☐Yes ☐No

14. **Provoking Factors:** (things that bring on a headache)

Food/beverage: ☐Fasting ☐Chocolate ☐Caffeine ☐Nitrates ☐MSG

☐Alcohol beverages_____ ☐Wine: [☐Red ☐White] ☐Other:_____

Physical exertion: ☐Coughing ☐Talking ☐Chewing ☐Exercise ☐Sexual intercourse

Hormonal: Menses: ☐Before ☐During ☐After

☐Pregnancy ☐Menopause

Stress: ☐Work ☐Home ☐Family ☐Spouse ☐Other:_____

Environmental: ☐Allergies ☐Weather changes ☐Altitude ☐Sunlight ☐Other:_____

Sleep: ☐Lack of sleep ☐Too much sleep ☐Change in wake/sleep

Other Triggers:_____

15. **Activity that worsens headache:**

☐None
☐Walking
☐Climbing steps
☐Exercise
☐Other:_____

16. **Relieving Factors:**

☐Lying down	☐Dark quiet room	☐Massage
☐Hot compress	☐Cold compress	☐Pregnancy
☐Keeping active/Pacing	☐Standing	☐Other:_____

17. **Allodynia:** Do you experience increased pain or an unpleasant sensation on your skin during your most severe type of headache when you are doing any of the following activities?

	Never	Rarely	< ½ the time	>½ the time	N/A
Combing your hair					
Wearing your hair up					
Shaving your face					
Wearing eye glasses					
Wearing contact lenses					
Wearing a necklace					
Wearing tight clothing					
Taking a shower					
Resting your head on a pillow					
Exposure to heat					
Exposure to cold					

Previous Treatments and testing:

1. **Previous Treatments/Procedures** (Please give date, type of treatment and if it helped)

Botox _____
Nerve Blocks _____
Trigger Points _____
Cefaly Device _____
TENS therapy _____
Acupuncture _____
Chiropractic Manipulation _____
Massage Therapy _____
Physiotherapy _____
Homeopathy _____
Transcranial Magnetic Stimulation _____

2. **Previous Tests** (Please give date and results)

☐Brain MRI _____
☐Head CT _____
☐MRA/MRV _____
☐Cervical MRI _____
☐Lumbar MRI _____
☐EEG _____
☐Lumbar puncture _____
☐EKG _____
☐EMG _____
☐Sleep study_____
☐Other:_____

Any other information you'd like to share with the team:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Past Medical History

Have you had any of the following medical problems?

☐Diabetes
☐Hypertension
☐Heart Disease
☐Stroke/transient ischemic attack
☐Seizures/epilepsy
☐Head injury
☐Ear, nose, and throat problems
☐Dental problems
☐Arthritis
☐Cervical neck/spine problems
☐Skin problems
☐Cancer
Type:_____
☐Hepatitis/liver disease
☐Deep vein thrombosis/phlebitis
☐Thyroid disease
☐Pulmonary disease
☐Asthma
☐Ulcers/gastrointestinal problems
☐Kidney/renal disease
☐Infectious disease
Type:_____
☐Gynecological problems
☐Psychiatric
☐Hospitalizations (See Below)
☐Other:_____

Review of Systems:

Have you been having any of the following symptoms **not** associated with your headache?

☐Fever
☐Fatigue
☐Double vision
☐Flashing lights
☐Obstructed vision
☐Tearing
☐Blurry vision
☐Congestion
☐Ringing in the ear
☐Chest pain
☐Rapid heartbeats
☐Shortness of breath
☐Abdominal pain
☐Frequent urination
☐Irregular periods
☐Neck pain
☐Muscle soreness
☐Rash
☐Cold hands and feet
☐Tremors
☐One-sided weakness
☐Loss of consciousness
☐Anxiety
☐Recent weight loss
☐Recent weight gain
☐Heat or Cold intolerance
☐Bruise easily

Social History:

Employment Status: ☐Part-time ☐Full-time ☐Retired ☐Disability

If disabled, why?_____

Type of work:_____ Occupation_____

Do you drink Alcohol? ☐Yes ☐No _____ drinks week/month

Do you smoke? ☐Yes ☐No _____ cigarettes a day/week

Do you do any illicit drugs? ☐Yes ☐No _____ type and times/week

Do you drink caffeine? ☐Yes ☐No _____caffeinated beverages a day/week

Do you exercise? ☐Yes ☐No _____times a week/month

Do you have difficulty sleeping? ☐Yes ☐No _____ hours a night

Are you sexually active? ☐Yes ☐No _____ form of contraception

Quality of Life Review:

1. **Over the last 2 weeks, how often have you been bothered by the following problems? (check one in each column)**

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Having trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

2. **Over the last 2 weeks, how often have you been bothered by any of the following problems? (check one in each column)**

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching TV				
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

Please list **ALL** medications you are currently taking including over the counter medications and vitamins

Medication Name	Dose	# of Time Taken per Day
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	

Previously Tried Preventatives (please circle)

Antidepressant/Antianxiety:
Amitriptyline (Elavil)
Nortriptyline (Pamelor)
Doxepin (Sinequan)
Protriptyline (Vivactil)
Imipramine (Tofranil)
Venlafaxine (Effexor)
Duloxetine (Cymbalta)
Escitalopram (Lexapro)
Citalopram (Celexa)
Buprioprion (Wellbutrin)
Mirtazapine (Remeron)
Clonazepam (Klonipin)
Buspirone (Busbar)
Haloperidol (Haldol)
Lithium
Fluoxetine (Prozac)
Sertraline (Zoloft)

Blood Pressure Medications:
Propranolol (Inderal)
Metoprolol (Lopressor/Toprol)
Timolol (Blocadren)
Atenolol (Tenormin)
Nadolol (Corgard)
Lisinopril
Enalapril (Vasotec)
Candesartan (Atacand)
Verapamil (Calan)
Flunarizine (Sibelium)
Diltiazem (Cardizem)
Clonidine
Amlodipine (Norvasc)
Felodipine
Nifedipine (Procardia)

Seizure Medications:
Valproic Acid (Depakote)
Topiramate (Topamax)
Gabapentin (Neurontin)
Levitiracetam (Keppra)
Pregabalin (Lyrica)
Lamotrigine (Lamictal)
Zonisamide (Zonegran)
Carbamazepine (Tegretol)
Oxcarbamazepine (Trileptal)
Phenytoin (Dilantin)

Vitamins:
Magnesium
Feverfew
Riboflavin (Vitamin B2)
Coenzyme Q10
Petadolex (Butterbur)
Melatonin
Periactin
Migralief

Other:
Indomethacin
Methergine
Sansert
Namenda
Zyprexa
Seroquel
Diamox

Previously Tried Abortives (Please Circle)

Anti-inflammatory:
Ibuprofen (Advil, Motrin)
Naproxen (Naprosyn, Anaprox, Aleve)
Aspirin
Acetaminophen
Excedrin
Fioricet
Fiorinal
Nabumetone (Relafan)
Ketoprofen
Mefenamic Acid (Ponstel)
Ketorolac (Toradol)
Celecoxib (Celebrex)
Oxaprozin (Daypro)
Piroxicam (Feldene)
Flurbiprofen (Ansaid)
Diclofenac (Cambia, Voltaren, Arthrotec)
Steroids (Medrol, Prednisone, Decadron)

Vasoactive:
Sumatriptan (Imitrex) SQ NS PO
Rizatriptan (Maxalt)
Zolmitriptan (Zomig) NS PO
Naratriptan (Amerge)
Eletriptan (Relpax)
Almotriptan (Axert)
Frovatriptan (Frova)
Treximet
Cafergot
Migranal NS
DHE IV

Muscle Relaxers:
Tizanidine (Zanaflex)
Methocarbamol (Robaxin)
Cyclobenzaprine (Flexeril)
Metaxalone (Skelaxin)
Orphenadrine (Norflex)
Carisoprodol (Soma)

Anti-nausea:
Ondansetron (Zofran)
Metoclopramide (Reglan)
Prochlorperazine (Compazine)
Promethazine (Phenergan)
Chlorpromazine (Thorazine)
Trimethobenzamide (Tigan)

Opiates:
Codeine
Oxycodone (Percocet, Percodan)
Hydrocodone (Vicodin, Vicoprofen)
Meperidine (Demerol)
Hydromorphone (Dilaudid)
Fioricet/Fiorinal w Codeine
Hydrocodone (Lortab)
Morphine
Oxycontin
Stadol NS

Other:
Diphenhydramine (Benadryl)
Hydroxyzine (Vistaril)
Lidocaine NS IV
Oxygen
Diazepam (Valium)
Alprazolam (Xanax)
Clonazepam (Klonipin)