Name_____ _____

First Middle Last Today's Date

Providers you would like to have office notes shared with: _____

Your email address:_____

Medication Allergies	
Name of Medication	Reaction

Current Medications		
Name of Medication	Dose/Milligrams	How many times a day?

Family History:

Put a check in the collum if any of these family members has a history of these medical conditions. If you have more than one sibling, add them on at the bottom.

Family Member	Seizures	Headaches	Tremor	Heart Disease	Diabetes	Strokes
Mother's Mother						
Mother's Father						
Father's Mother						
Father's Father						
Your Mother						
Your Father						
Your Brother						
Your Sister						
Your Mother's sibling						
Your Father's sibling						

Social History:

Are you able to care for yourself? ❒ Yes ❒ No
Are you blind or do you have difficulty seeing? ❒ Yes ❒ No
Are you deaf or do you serious difficulty hearing? ❒ Yes ❒ No
Do you difficulty concentrating, remembering, or making decisions? ❒ Yes ❒ No
Do you have difficulty walking, or climbing stairs? ❒ Yes ❒ No
Do you have difficulty dressing or bathing? ❒ Yes ❒ No
Do you have difficulty doing errands alone? ❒ Yes ❒ No
Which of your hands is dominant? ❒ Left ❒ Right
How many years have/did you smoke tobacco?_____What age did you start?_____
Do you or have you ever used any other forms of tobacco or nicotine? ❒ Yes ❒ No
How much alcohol do you consume [includes beer]? ❒ None ❒ Occasional [skip weeks] ❒Moderate [skip days] ❒ Heavy [daily]
Do you use any recreational drugs [includes medical marijuana]? If so, What?_____
How much caffeine do you use? ❒ None ❒ Occasional [skip days] ❒ Moderate [one/day] ❒ Heavy [more than one per day]

Lifestyle:

❒ Married ❒ Single ❒ Divorced ❒ Separated ❒ Widowed ❒ Domestic Partner

What is your highest level of education achieved? ❒ Less than 8th grade ❒ 9th ❒ 10th ❒ 11th ❒ 12th ❒ 2 yrs college ❒4 yrs college ❒ Post Grad

Are you currently employed? ❒ Yes ❒ No What is your occupation?_____

Are you sexually active? ❒ Yes ❒ No

Is your stress level? ❒ None ❒ Low ❒ Medium ❒ Moderate ❒ Low

Gender Identity: ❒ Male ❒ Female ❒ Transgender ❒ Non-Binary

Is this a work-related injury? ❒ Yes ❒ No

Is this an auto related injury? ❒ Yes❒ No

Is this in litigation or will it be in the future? ❒ Yes❒ No

Surgical History	Date

Montana Headache Clinic

YOUR Past Medical History	Yes	No	YOUR Past Medical History	Yes	No
ADHD			Chronic Pain		
Alzheimer's Disease			Color Blind		
BPV			Deep vein thrombosis		
Bipolar			Degenerative spine disease		
COPD			Depression		
Coronary Artery Disease			Dyslipidemia		
Diabetes			Dysthymia-persistent depressive disorder		
Epilepsy			Eating Disorder		
Guillain-Barre Syndrome			Encephalitis		
HSV 1 [herpes]			Fibromyalgia		
Hepatic [liver] failure			Head trauma		
Hepatic insufficiency			Headaches/migraines		
Hepatitis C			Hearing loss		
High blood pressure			Heart disease [clogged arteries]		
OSA – obstructive sleep apnea			Heart murmur		
PLMD-periodic limb movement disorder			Hepatic [liver] cysts		
PTSD			Major depression		
RLS- restless leg syndrome			Meningitis		
Seizures			Multiple sclerosis		
Sjogren's syndrome			Osteoarthritis		
Stroke			Panic attacks		
TBI			Peripheral vascular disease		
Acid reflux			Pulmonary embolism		
Anxiety disorder			Renal calculi [kidney stones]		
Asthma			Rheumatoid arthritis		
Beta thalassemia			Scoliosis		
Brain tumor			SVT [supraventricular tachycardia]		
Breast cancer			Systemic lupus erythematosus		
Cancer			Thyroid disease		
Cerebral palsy			Vertigo		

Problems you have had in the LAST MONTH. Put a check in the box beside all that apply:

Bladder problems		Speech problems		Muscle Cramps		Blurred vision	
Bowel problems		Convulsions		Headaches		Vison loss	
Numbness		Syncope		Vertigo/Dizziness		Double vision	
Tingling		Blackouts		Loss of hearing		Difficult walking	
Confusion		Weakness		Tinnitus			
Memory loss		Muscle Twitching		Imbalance or falling			

HEADACHE SPECIFIC QUESTIONS

Please answer these questions with as much detail as you think I need to know to help me understand your headaches and be prepared for our first visit.

The term “headaches” is a general term for head pain. Underneath that term the American Headache Society has criteria for hundreds of different types. You will hear me call them all headaches.

If you need additional space to answer a question, note that you went to the back of the page.

1. When do you remember having your very FIRST headache [NOT MIGRAINE, FIRST HEAD PAIN EVER IN YOUR LIFE]?

2. Does anyone else in your family have HEADACHES [even aunts, uncles, cousins, grandparents]? Doesn’t have to be anything like what you have just answer the question.

3. Have you ever had a concussion, lost consciousness, brain infection, or other head injuries?

4. How have you managed/treated your headaches in the past? What worked, what didn’t work?

5. If you could take one piece of the headache song and dance away that would make the rest of it almost seem bearable what would that be? Ex. The nausea

6. Have you ever had an MRI or CT scan of your head? If so, where was it done?

7. How many times a WEEK do you take Tylenol®/acetaminophen?

8. How many times a WEEK do you take ibuprofen/Motrin®?

9. How many times a WEEK do you take Excedrin®?

10. How many times a WEEK do you take Aleve®/naproxen?

11. How many times a WEEK do you use/consume marijuana?

12. Have you used ice on your head/what happened?

13. Have you used heat on your head/what happened?

14. Have you had physical therapy for this?

    a. Did it help?
    b. How long ago was it?

15. If I have left out anything that you feel would be helpful, feel free to tell me here. If there is not enough space, turn the page and write on the back.

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Head Pain Questions

0 = no pain and 10 = worst possible pain imaginable

- How bad does your head pain get during your <u>mildest</u> head pain days? 0 1 2 3 4 5 6 7 8 9 10

- How bad does your head pain get during your <u>worst</u> head pain days? 0 1 2 3 4 5 6 7 8 9 10

- In the last year, on average how many months have you had head pain?

  ❑ 0-3 ❑ 4-6 ❑ 7-9 ❑ 10-12

- How many days per month on average is your head totally pain free? _____

- How long does your head hurt <u>UNTREATED?</u> ❑ Less than 4 hours ❑ 4 hours or more

- Is the pain worse with movement [ex. coughing, sneezing, shaking your head, bending over, walking, exercise]?

  ❑ Never ❑ Sometimes ❑ Usually ❑ Almost Every Time ❑ Every time

- What is the character of your head pain? [Select all that apply]

Pressure ❑

Sharp ❑

Pounding ❑

Stinging ❑

- What symptoms do you usually have with your headache?

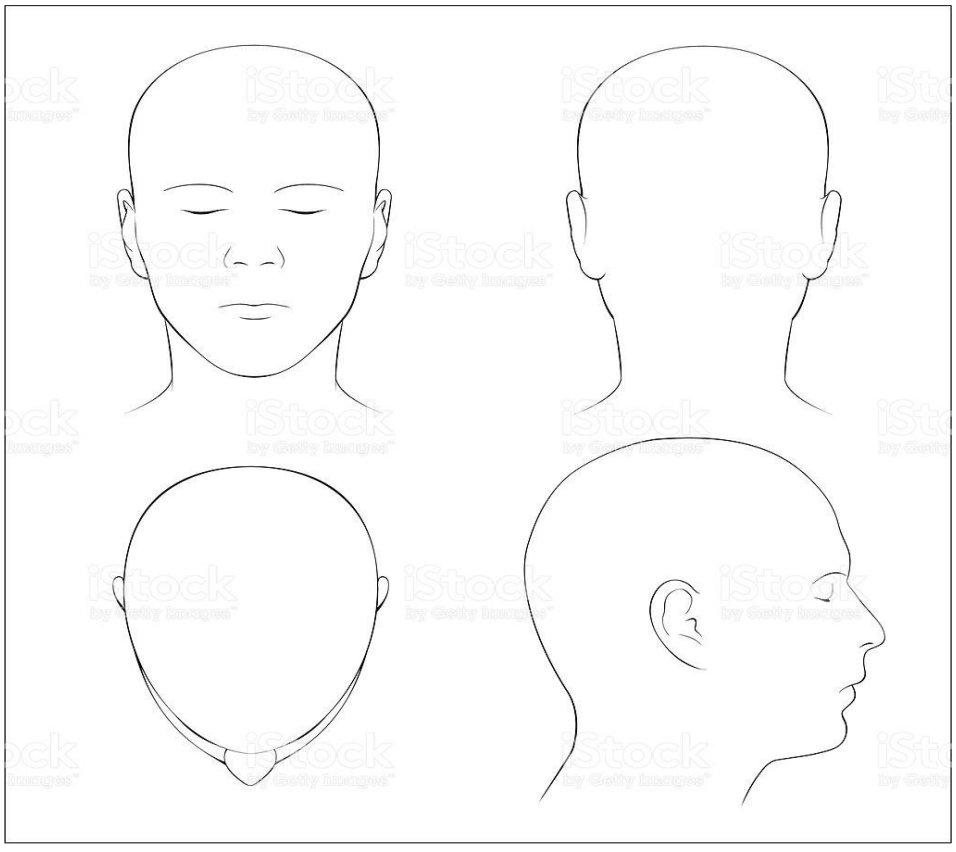
Sensitivity to sound ❑

Vomiting ❑

Sensitivity to light ❑

Nausea ❑

- Mark the location or locations where your headaches/migraines most often start on your head.



The next page is important for getting medications approved through your insurance.

HEADACHE/MIGRAINE **PREVENTATIVE** MEDICATIONS TRIED			
	Name of Medication Tried	**From About When to About When Was it Used?**	**Why Did You Stop?**
Antiseizure Medications: (e.g. Depakote, Topamax)			
Beta-blockers: (e.g. metoprolol, propranolol, atenolol)			
Calcium channel blockers: (e.g. Verapamil)			
Antidepressants: (e.g. amitriptyline, Cymbalta, venlafaxine)			

HEADACHE/MIGRAINE **ELIMINATION** MEDICATIONS TRIED			
	Name of Medication Tried	**From About When to About When Was it Used?**	**Why Did You Stop?**
Analgesics/NSAIDs: (e.g. Tylenol, aspirin, diclofenac, ibuprofen, aleve/naproxen, etc)			
Ergot: (e.g.ergotamine, dihydroergotamine, migranol)			
Triptans: (e.g. sumatriptan, rizatriptan, zolmitriptan)			
gePants: (e.g. Nurtec or Ubrelvy)			
5-HT1F Agonist: (Reyvow)			
Opioids: (e.g. Hydrocodone, Oxycodone, etc)			
Other: (e.g. marijuana, acupuncture, etc)			

- How often do you need to go to a **dark room** because of your headaches/migraines?
    - Never
    - Sometimes
    - Usually
    - Almost Every time
    - Every time
- How often do headaches/migraines **limit your ability** to complete tasks such as errands or household chores?
    - Never
    - Sometimes
    - Usually
    - Almost Every time
    - Every time
- How often do you **miss work or school** due to headaches/migraines?
    - Never
    - Sometimes
    - Usually
    - Almost Every time
    - Every time
- How often do you **miss social, family, or leisure activities** due to headaches/migraines?
    - Never
    - Sometimes
    - Usually
    - Almost Every time
    - Every time