HEADACHE HISTORY

NAME____________________________ TODAY'S DATE_________________

PRESENT AGE____________________ SEX____________________________

BEGAN:

1. Headaches started______ years ago
Age of onset:
_________under 20;_________20-30;____________31-50;__________over 50 years old

CAUSE:

2. __ Injury: type____
______________________________________Date of injury_____________________

_____no injury: _________ infection;_________ pregnancy;________

Emotional stress______________other:____

FREQUENCY:

3. Headaches occur ________times each_________________(day, week, month)
Are they increasing? _____ Yes______ No

LOCATION:____
____

4. Starts _______ left side: _______right side: ________either side: ______all over head (hatband): _______face/jaw ____________other:______________

5. _________usually stays in one place: _____________sometimes moves around ____________often moves around; If they move around, please explain:

____

____

DURATION:

6. Lasts _______________if not treated: ________________if treated immediately____ if treated after they are severe _________

7. Free of headaches from ________________________to________________________
______Never been free of headaches

PRECIPITATING FACTORS:
8. Headache can be brought on by:
___________fatigue;_________stress/tension;_______oversleeping;_____________
Certain foods __________alcohol ______________certain medications;______________
Menstruation __________ coughing __________shaving or touching face;____________
Washing ___________ chewing ____________talking _________ lying down;_______
Stooping ______exercise __________other:____________________________________

HORMONAL:
(WOMEN ONLY)
9. A: Headaches affected by menstrual cycle (how?)_____________________________
B: Headaches affected by pregnancy (how?)_________________________________

SEASONALITY:
10. More frequent in ______________spring ______________ summer
________Fall ____________winter ________________not seasonal

PRODROMATA:
11. Warnings before headaches:
___________halos around eyes _____________blind spots _________upset stomach;
_______________feeling of tightness around head __________________flashing lights;
_________________dizziness ______________________light-headed ____________
Numbness in leg or arm _______________________other:________________________

PAIN TYPE:
12. Pain is __________throbbing; _______dull; ___________sharp;____ tight band
________stabbing __________ burning
Other:____

SEVERITY:
13. Pain is _________mild to moderate; ________severe; _______very severe;
______________________unbearable
14. Headache prevents normal activities such as work. __________Yes __________No

FAMILY HISTORY:
15. Relatives with headaches:____

ASSOCIATED SYMPTOMS:
16. Symptoms accompanying headache:
_________nausea and vomiting; __________insomnia; __________frequent and/or early awakening; ________light sensitivity; __________sound sensitivity; _________tinnitus; ___________eye tearing; _____________visual disturbance; ____________nasal congestion; ____________dizziness; __________ parethesia; _______stiff neck;
other:____
____

PREVIOUS CARE:

17. Other doctors seen for headache treatment?____

____

18. What tests/x-rays because of headaches?_________________________________

19. Medications taken for headaches:_______________________________________

____

20. Other treatments, such as biofeedback, for headaches?_______________________

____

21. Medical history

____________asthma;__________cancer/tumor;__________diabetes;________epilepsy; ________eye problems; _________allergies; __________head injury; _________hearing problems; _________heart trouble; ________high blood pressure ________kidney/liver disease; _______nervous breakdown; ________sinusitis; ________stomach/duodenal ulcer

22. Current medications, other than those for headaches:________________________

____

23. Allergic to medications?____

24. Allergic to foods? ____________cheese; _________________________chocolate; __________cola drinks; ____________nuts; ___________MSG (monosodium glutamate);

___________spicy foods; _____________other:_________________________________

25. Hospitalization (for other than normal pregnancy):___________________________

____

26. Drinks alcoholic beverages? __________________Yes ____________________No

Average daily consumption: ____________________

27. Tobacco use ___________Yes _____________No Average per day:____________

28. History of fainting _____________________;seizures_________________________

29. Problems with ears or eyesight: ____

30. History of drug abuse? ___________prescribed_____________; non-prescribed ___

31. WOMEN ONLY

Number of pregnancies:____

Number of children born alive:____

32. Additional general health comments:_____________________________________

____

Systems review (X) if you have any of the following:

GENERAL
__Frequent Headaches
__Lethargy/weakness
__Weight loss
__Dizzy Spells
__Fainting spells/unconsciousness
__Chills/night sweats/fever
__Sleep difficulties

EYES
__Wears glasses
__Eyesight worsening
__Double vision
__Pain in eyes

EARS/NOSE/THROAT
__Deafness
__Noise in ears
__Congestion/sneezing
__Sinus trouble/hay fever
__Nose bleeds
__Sore throat/tongue
__Hoarse voice
__Dental problems

HEART
__Chest pain
__Heart attack
__Heart murmur
__Heart racing/palpations
__Swollen feet/ankles

LUNGS
__Wheezing/coughing spells
__Coughing up phlegm
__Shortness of breath
__Chest pain
__Coughing up blood

STOMACH
__Difficulty swallowing
__Ulcers
__Heart burn/indigestion
__Constipation
__Stomach pain
__Vomiting blood
__Recent change in bowel habits
__Loose stool/diarrhea
__Black or bloody stools

KIDNEY/BLADDER/PROSTATE
__Frequent day or night voiding
__Burning or urination
__Pus or blood in urine
__Difficulty starting urine
__Dribbling with coughing or sneezing
__Other kidney disease
__Sex difficulties
__Prostate disease

NEUROLOGY/SKELETAL
__Difficulty making decisions
__Memory Problems
__Numbness or tingling
__Weakness
__Aching muscles/joints

PSYCHIATRY
__Cry often/depressed/sad
__Worry a lot
__Considered suicide
__Loss of interest in eating
__Anxiety/tension
__Loss of energy

HEMATOLOGY/IMMUNOLOGY
__Bleed/bruise easily
__Anemia/low blood
__Blood disease
__Enlarged glands/nodes

ENDOCRINE
__Tired
__Weak
__Thirsty
__Swelling
__Skin changes

BREAST/MENSTRAL
__Lumps in breast
__Last menstrual period_____
__Menstrual irregularity

SKIN
__Rash
__Sores