Advanced Neuroscience Clinic, P. A. **Headache History**

Date:_______________

Name ____ DOB:_______________

1. **When did your headaches start?** #___days ago, #___weeks ago, #____months ago, #_______years ago

2. **Are your headaches getting worse recently** ❑ No ❑ Yes → if yes for how long #_______days ago, #____weeks ago, #_____months ago, #________years ago

3. **Did your headache start after a head injury?** ❑ No ❑ Yes → if yes, describe injury_______________

4. Did your headache start after an infection? ❑ No ❑ Yes → if yes, what infection? ________________________

5. Did your headache begin when you started or changed a medication? ❑ No ❑ Yes → if yes, which medication?____

6. How many days in a month do you have a headache? _________How many headache-free days do you have in a month? ________.

7. **Do you have more than one type of headache?** ❑ Yes ❑ No → If yes, focus the following questions on your worst headache type.

8. **Premonitory symptoms** (you experience one or more of these symptoms 1 to 2 days **Before** onset of headache)

❑ Hyperactive
❑ Depressed feeling
❑ Irritability
❑ Feeling sluggish
❑ Difficulty concentrating
❑ Other
❑ Difficulty with speech
❑ Sensitive to light
❑ Sensitive to sound/noise
❑ Dizziness
❑ Excessive yawning
❑ Food cravings
❑ Increased appetite
❑ Decreased appetite
❑ Increased urination
❑ Stiff neck

9. **Aura**: (Do you have these symptoms **Before or With** your headache begins?)

Visual:

❑ Blur
❑ Flashing lights
❑ Bright flashes
❑ Zigzag lines
❑ Wavy lines
❑ Loss of vision in one eye
❑ Loss of vision on one side
❑ Total blindness
❑ Double vision
❑ Distorted vision
❑ Spots: bright/dark
❑ Other:___________

Sensory and Other:

❑ Numbness/tingling [R L Both] Duration: _______________
❑ Speech difficulty
❑ Vertigo
❑ Dizziness/unsteadiness
❑ Light headedness
❑ Difficulty finding words
❑ Speech arrest
❑ Confusion/déjà vu/hallucinations
❑ One-sided weakness of face [R L Both]
❑ One-sided weakness of body [R L Both]
❑ Other:

If you have any of these symptoms above, how long they usually last:______________minutes _______hours ________days and terminate____________minutes before pain starts OR occur ❑ during the head pain ❑ after the head pain ❑ without the head pain.

10. Your headaches usually feel like: (check all that apply)

❑ Throbbing/Pulsing	❑ Dull	❑ Shooting
❑ Achy	❑ Stabbing	❑ Burning
❑ Tight	❑ Pressure	❑ Other

Please fill if you have 2 types of headaches.
2nd type of headache How does it feel?

❑ Throbbing/Pulsing	❑ Dull	❑ Shooting
❑ Achy	❑ Stabbing	❑ Burning
❑ Tight	❑Pressure	❑Other

11. Where are your headaches located in general? (check all that apply)

❑ Only right side ❑ starts right side and radiates to the left side

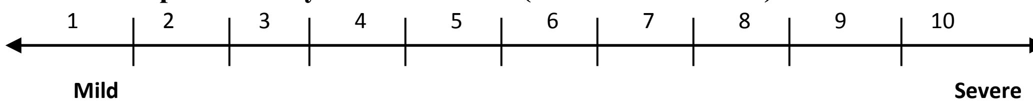
❑ Only left side ❑ starts left side and radiates to the right side

❑ Both sides headache at the same time

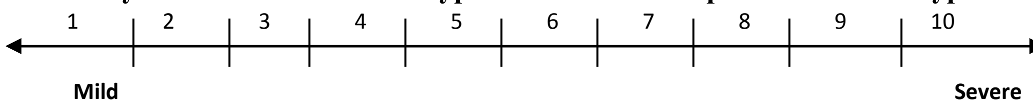
Exact Location\s (Check all that apply)

Right	Yes	NO	Left	Yes	NO
Front			Front		
Eye			Eye		
Side Temple			Side Temple		
Back of head			Back of head		
Top of Head			Top of Head		
Face			Face		
Entire Head					

12. How painful are your headaches? (Circle one number)



13. If you have more than one type of headache how painful is second type of headache? (Circle one number)



14. How long do your headaches last in <u>HOURS</u>?
Shortest ______Longest_______Average_____ or are they constant? ❑ Yes ❑ No

15. Your headaches are worse in the ❑ morning ❑ afternoon ❑ evening ❑ during the night ❑ no pattern

16. Are your headaches worse ❑ lying down or ❑ standing? ____________ Or ❑ no change laying down or standing.

17. Do your headaches wake you up in the middle of the night? ❑ Yes ❑ No; if yes, how often? _____________

18. Do you have any of the following symptoms during your headache? (mark all that apply)

❑ Nausea or upset stomach/vomiting	❑ Sensitivity to smells
❑ Sensitivity to light (prefer a dark room)	❑ Difficulty thinking/concentrating/focus
❑ Sensitivity to sound (prefer a quiet room)	❑ Difficulty speaking/slurred speech
❑ Sore/stiff neck	❑ Increased Urination
❑ Vision changes (blurred, spots, patterns)	❑ Anxiety
❑ Eye tearing in only ❑one eye or ❑both eyes	❑ Irritability
❑ Runny nose in only ONE NOSTRIL	❑ Memory problems
❑ Ringing in ears	❑ Increased appetite
❑ Eye-redness [❑Right ❑Left ❑Both]	❑ Decreased appetite
❑ Drooping eyelid [R L Both]	❑ Diarrhea
❑ Swelling of eyelid [R L Both]	❑ Constipation
❑ Change in pupil [Larger Smaller]	❑ Insomnia
❑ Dizziness/vertigo	❑ Sleepiness
❑ Imbalance	❑ Numbness/Tingling [R L Both] where?__________
❑ Confusion	❑ Odor sensitivity
❑ Nasal stuffing / running	❑ Scalp tenderness
❑ Neck tenderness	❑ Sweating
❑ Flushing	❑ Skin sensitivity
❑ Weakness	❑ Pupil dilated
❑ Stroke like symptoms (facial droop, droopy eye lid, unable to move one arm or leg	❑ Eye lid drooping / swelling
	❑ Other______________________________

19. Other Headache Characteristics (mark all that apply)

Does this headache wake you from your sleep: ❑ Yes ❑ No

Have you ever had a serious head injury with loss of consciousness: ❑ Yes ❑ No Date:__________

Have you had any history of mild head injury (sports, whiplash assault, etc): ❑ Yes ❑ No Date:__________

Have you had a recent viral illness prior to headache onset: ❑ Yes ❑ No Date:__________/
Explain:____

20. Provoking Factors (Triggers = things that bring on a headache)

Food/beverage: ❑ Fasting/skipping meals ❑ Chocolate ❑ Caffeine Nitrates ❑ MSG Aged cheese

Alcohol beverages: ❑ Wine: [❑ Red ❑ White] ❑ Other:________________________

Physical exertion: ❑ Coughing ❑ Talking ❑ Chewing ❑ Exercise ❑ Position ❑ Sexual intercourse

Emotional-Hormonal: ❑ Anger ❑ Anxiety ❑ ❑ Depression ❑ Fatigue ❑ Pregnancy ❑ Menopause
❑ Menstrual cycle ❑ Before ❑ During ❑ After;

Stress: ❑ Work ❑ Home ❑ Family ❑ Spouse ❑ Other: ____________________________________

Environmental: ❑ Allergies ❑ Weather changes ❑ Altitude ❑ Sunlight ❑ Sound ❑ Smell ❑Travel ❑Temperature

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

21. Activity that worsens headache:

❑ None ❑ Walking ❑ Climbing steps ❑ Exercise ❑ Other:________________

22. Relieving Factors:

❑ Lying down ❑ Dark quiet room ❑ Hot compress ❑ Massage
❑ Standing ❑ Ice/Cold compress ❑ Keeping active/pacing ❑ Pregnancy
❑ Other:__________________

23. What medication have worked best for you: ____

24. What medications have worked best for a family member with headaches: _________________________________

25. Have you needed to go to the hospital or emergency room (ER) for headaches? ❑ Yes ❑ No If yes, how many times in the last 6 months? ____________________Name of Hospital OR Emergency room_____________________

26. Testing

Have you had any of the following?

Test		Where	Date
CT Brain	❑ Yes ❑ No		
MRI Brain	❑ Yes ❑ No		
CT Neck	❑ Yes ❑ No		
MRI Neck	❑ Yes ❑ No		
Spinal Tap	❑ Yes ❑ No		
Eye Exam	❑ Yes ❑ No		
Dental Exam	❑ Yes ❑ No		
Allergy Test	❑ Yes ❑ No		
Any Other Test:			

27. Have you been treated in the infusion clinic for your headaches? ❑ Yes ❑ No If yes, how many times in the last 6 months? ______________

What did you receive in the ER or Infusion clinic?	Did it help? YES/NO	If headache returned, how long after treatment?
IV cocktail		
DHE (dihydroergotamine)		
Pain medication (narcotics)		
Steroid		
Other:		

28. Procedures to help headache (check all that apply):

Occipital nerve blocks: ❑ No ❑ Yes	Supra-orbital/Supra-trochlear nerve block: ❑ No ❑ Yes
Auriculotemporal nerve blocks: ❑ No ❑ Yes	Head/Neck injections under X-ray guidance: ❑ Yes ❑ No

Botox injections: #_Last______months ago Other procedures ___________________________________

29. Alternative and Behavioral treatments used

Supplements		Did it help?	How Long did you take it?	Behavioral/Physical therapy		Did it help?	How Long did you take it?
Multivitamin/multi mineral	❑	Y / N		Psychologist, therapist	❑	Y / N	
Riboflavin (vitamin B2)	❑	Y / N		Physical therapy	❑	Y / N	
Magnesium	❑	Y / N		Massage	❑	Y / N	
Co-enzyme Q10	❑	Y / N		Chiropractic therapy	❑	Y / N	
Melatonin	❑	Y / N		Acupressure/puncture	❑	Y / N	
Petasides (Butterbur)	❑	Y / N		Biofeedback	❑	Y / N	
Iron	❑	Y / N		Yoga	❑	Y / N	
Feverfew	❑	Y / N		Other:	❑	Y / N	

MIDAS DISABILITY ASSESSMENT

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you.

	# of **DAYS**
1. On how many days in the last 3 months did you miss work or school because of your headaches? (If you did not attend work or school enter zero in the box.)	
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? *(Do not include days you counted in question 1 where you missed work or school. If you do not attend work or school enter zero in the box.)*	
3. On how many days in the last 3 months did you not do household work because of your headaches?	
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? *(Do not include days counted in question 3, where you did not do household work.)*	
5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches?	
Total Score	

Office use only Score

0-5	*Grade I Minimal or no Disability*
6-10	*Grade II Mid Disability*
11-20	*Grade III Moderate Disability*
21+	*Grade IV Severe Disability*

GENERAL ANXIETY DISORDER SCALE (GAD-7)				
Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
	Score: 0	Score: 1	Score: 2	Score: 3
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Becoming easily annoyed or irritable				
6. Feeling afraid as if something awful might happen				
Total Score				

Office use only: 5 Mild, 10 moderate, 15 severe anxiety

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with people? ❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult

ALLODYNIA QUESTIONNAIRE (ASC-12)					
How often do you experience increased pain or an unpleasant sensation on your skin during your most severe type of headache when you engage in each of the following?	**Does not apply to me**	**Never**	**Rarely**	**Less than half the time**	**Half of the time or more**
	Score: 0	Score: 0	Score: 0	Score: 1	Score: 2
Combing your hair					
Pulling your hair back (e.g., ponytail)					
Shaving your face					
Wearing eyeglasses					
Wearing contact lenses					
Wearing earrings					
Wearing a necklace					
Wearing tight clothing					
Taking a shower (when the water hits your face)					
Resting your face or head on a pillow					
Exposure to heat (e.g., cooking, washing your face with hot water)					
Exposure to cold (e.g., using an ice pack, washing your face with cold water)					
Total scores					

Office use only: 0-2 none, 3-5 mild, 6-8 moderate, 9+ severe allodynia

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
	Score: 0	Score: 1	Score: 2	Score: 3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless than you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
Total scores				

Office use only: 5 Mild, 10 moderate, 15 moderately severe, 20 severe

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? ❑ Not difficult at all ❑ Somewhat difficult ❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult Very difficult ❑ Extremely difficult

Are you currently being treated for ❑ Depression ❑ Anxiety

30. Which **Acute medications** have you tried (medications taken to stop a headache)?

Acute (as needed) medication **Tried**	Check mark which one tried	On average, how many days per week?	Helps or Helped? YES/NO	Currently taking? YES/NO
Acetaminophen (Tylenol)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Aleve (Naprosyn, Naproxen)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Almotriptan (Axert)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Aspirin	❑		❑ Yes ❑ No	❑ Yes ❑ No
Baclofen (Lioresal)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Celecoxib (Celebrex)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Cyclobenazeprine (Flexeril)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Diclofenac (Cambia)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Dihydroergotamine (Migranal, DHE)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Diphenhydramine (Benadryl)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Eletriptan (Relpax)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Excedrin	❑		❑ Yes ❑ No	❑ Yes ❑ No
Fioricet, Fiorinal	❑		❑ Yes ❑ No	❑ Yes ❑ No
Frovatriptan (Frova)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Ibuprofen (Advil/Motrin)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Indomethacin (Indocin)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Ketorolac (Toradol)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Lidocaine nasal spray	❑		❑ Yes ❑ No	❑ Yes ❑ No
Metaxalone (Skelaxin)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Metoclopramide (Reglan)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Midrin (Duradrin, Epidrin)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Naratriptan (Amerge)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Ondansetron (Zofran)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Prochlorperazine (Compazine)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Promethazine (Phenergan)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Rizatriptan (Maxalt)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Sumatriptan (Imitrex)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Tizanidine (Zanaflex)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Tramadol (Ultram)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Vicodin, Codeine, Demerol, Percocet	❑		❑ Yes ❑ No	❑ Yes ❑ No
Zolmitriptan (Zomig)	❑		❑ Yes ❑ No	❑ Yes ❑ No
Other:	❑		❑ Yes ❑ No	❑ Yes ❑ No

31. Preventive medications (Have taken or currently taking to prevent headaches)

DRUG		Helped	Did Not Help	DRUG		Helped	Did Not Help
Nonsteroidal Anti-inflammatories				**Anxiety/Depression**			
ibuprofen (Motrin, Advil)	❑			aripiprazole (Abilify)	❑		
naproxen (Naprosyn)	❑			olanzapine (Zyprexa)	❑		
celecoxib (Celebrex)	❑			quetiapine (Seroquel)	❑		
piroxicam (Feldene)	❑			risperidone (Risperdal)	❑		
diclofenac (Voltaren)	❑			ziprasodone (Geodon)	❑		
indomethacin (Indocin)	❑			diazepam (Valium)	❑		
meloxicam (Mobic)	❑			clonazepam (Klonopin)	❑		
nabumetone (Relafen)	❑			alprazolam (Xanax)	❑		
Cardiac Medication				lorazepam (Ativan)	❑		
timolol (Blocadren)	❑			**Anti-Seizure Medication**			
nadolol (Corgard)	❑			valproic acid (Depakote)	❑		
propranolol (Inderal)	❑			gabapentin (Neurontin)	❑		
metoprolol (Lopressor,Toprol)	❑			pregabalin (Lyrica)	❑		
atenolol (Tenormin)	❑			phenytoin (Dilantin)	❑		
verapamil	❑			carbamazepine (Tegretol, Carbatrol)	❑		
amlodipine (Norvasc)	❑			oxcarbazepine (Trileptal)	❑		
nifedipine (Procardia)	❑			topiramate (Topamax)	❑		
diltiazem (cardizem)	❑			lamotrigine (Lamictal)	❑		
clonidine (Catapress)	❑			zonisamide (Zonegran)	❑		
Anxiety/Depression Medication				tiagabine (Gabatril)	❑		
nortriptyline (Pamelor)	❑			**Muscle Relaxants**			
imipramine (Tofranil)	❑			carisoprodal (Soma)	❑		
doxepin (Sinequan)	❑			cyclobenzaprine (Flexeril)	❑		
Desipramine	❑			methocarbamol (Robaxin)	❑		
protriptyline	❑			tizanidine (Zanaflex)	❑		
fluoxetine (Prozac)	❑			baclofen (Lioresal)	❑		
sertraline (Zoloft)	❑			orphenadrine (Norflex)	❑		
paroxetine (Paxil)	❑			metaxalone (Skelaxin)	❑		
citalopram (Celexa)	❑			**Pain Medications**			
escitaloproam (Lexapro)	❑			hydrocodone / apap (Lortab, Vicodin)	❑		
venlafaxine (Effexor)	❑			acetaminophen with codiene (Tylenol #3)	❑		
desvenlafaxine (Pristiq)	❑			extended release oxycodone (Oxycontin)	❑		
duloxetine (Cymbalta)	❑			extended release morphine	❑		
mirtazapine (Remeron)	❑			fentanyl patch (Duragesic)	❑		
fluvoxamine	❑			methadone	❑		
trazodone (Desyrel)	❑			tramadol (Ultram)	❑		
efazodone (Serzone)	❑			tapentadol (Nucyncta)	❑		
bupropion (Wellbutrin)	❑			oxymorphone (Opana)	❑		
phenalzine (Nardil)	❑			**Continued Next page**			

(continued) **Preventive medications** (taken daily to prevent headaches)

DRUG		Helped	Did Not Help
Sleep Medications			
zolpidem (Ambien)	❑		
zaleplon (Sonata)	❑		
eszopiclone (Lunesta)	❑		
ramelteon (Rozerem)	❑		
chloral hydrate (Somnote)	❑		
melatonin	❑		
other:	❑		
Other	❑		
methysergide (Sansert)	❑		
cyproheptadine (Periactin)	❑		
memantine (Namenda)	❑		

Any additional information that you think is important regarding your headache. Please write below