PEACHTREE NEUROLOGICAL CLINIC - HEADACHE CENTER

NAME: _____ Age_____ I write with my _____ hand
Date of visit:_____ Referring physician _____
Height: _____ Weight _____ Pulse _____ BP _____

For each type of headache you have, list separately:

QUESTION	Headache Type 1	Headache Type 2
LOCATION (which part(s) of head hurt(s))		
ASSOCIATED SYMPTOMS (check where applicable) a) Nausea or vomiting b) Light sensitivity c) sound sensitivity d) Odor sensitivity e) Numbness and tingling f) Difficulty sleeping g) Neck pain/stiffness h) Dizziness/vertigo i) Mood changes j) Fainting or loss of consciousness k) Tearing l) Nasal stuffiness or congestion m) Memory problems n) None of the above		
PAIN INTENSITY GRADE: 0 = none 10 = worst possible		
PAIN DURATION for Each type		
TYPE OF PAIN: throbbing, pulsing, stabbing, pressure		
HEADACHE ONSET (Time of day, week or Menstrual cycle)		
WARNING SYMPTOMS Before the headache begins		
HEADACHE TRIGGERS (Food, alcohol, activity, weather)		
DATE HEADACHES BEGAN Related to an injury (Y/N)		
CURRENT NUMBER OF HEADACHES PER WEEK		
ANY CHANGE IN PAST 6 - 12 MONTHS? (Severity, frequency, or associated symptoms)		

OVER-THE-COUNTER MEDICATIONS OR HERBS USED WITH NUMBER OF TABLETS PER WEEK

PRESCRIBED MEDICINES TRIED WITH NUMBER OF TABLETS PER WEEK

Which helped _____

Undesired effects _____

DOES THE HEADACHE INTERFERE WITH YOUR NORMAL ACTIVITIES? YES _____ NO _____

HOW MANY MISSED WORK DAYS PER WEEK? _____ PER MONTH? _____

DOES SLEEPING OR LYING DOWN HELP OR WORSEN YOUR HEADACHE? _____

OTHER ACTIVITIES WHICH CAUSE HEADACHE? _____

Is your sleep regular? _____ How many times do you wake up during the night? _____

Do you sleep during the day? _____ Do you wake up refreshed in the morning? _____

Circle each which applies to you Happy Sad Depressed Anxious Subject to panic attacks

Do you have crying spells? If so, please explain _____

Do you ever think about suicide? _____ Do you have mood swings? _____

How is your appetite for food? _____ How is your performance at work? _____

How is your interest in: Sex _____ Exercise _____ Friendships _____

(Women only) Last menstrual period began on (date) _____

Have you had any tests: CT or MRI of head (Y/N) _____ When and where? _____
EEG _____ _____
Spinal tap? _____ _____

Please list surgical operations with dates: _____

_____

Please list all other medical problems with dates _____

_____

Please list all prescribed medicines you are now taking _____

_____

Medications allergies: _____

Your occupation _____Highest level of education completed _____

Your marital status _____ Number and ages of any children _____

Tobacco use(type and amount) _____ Caffein-containing beverages consumed (amount daily) _____

Alcohol use (Y/N) _____Type and weekly amount of alcoholic beverages consumed _____

List any Medical History in blood relatives, of brain tumor, aneurysm, stroke, headaches, hypertension: _____

_____

List any family heart deaths before age 50 _____

_____