Providence
Medical Group

Headache and Health History Questionnaire

Name:______________________________Today's Date:____________________

Date of Birth:__________________ Age:__________ Height:________ Weight:________

PCP:__________________________ Referring Provider?____________________

Why are you seeing the doctor today?____________________________________

____

Please list any major complaint(s) and describe their onset (i.e., lower back began in May 2012 after lifting):

____

____

____

Are you having any? □ Numbness Where?________________

□ Weakness Where?________________

Is this visit related to an injury? □Yes □No On the job? □Yes □No

If so, date of injury: ________________ Date of last employment:________________

Do you have any open worker's compensation claims of any kind? □Yes □No

Do you have a lawsuit pending? □Yes □No

Please circle the description which applies to your intensity of pain: Stable, unchanged, gradually worsening, rapidly

Worsening, gradually improving, rapidly improving, completely resolved.

What started the pain/problem?____________________________________

____

Previous physicians seen for this problem?

Physician	Specialty	City	Treatment

Onset of headache:

□ Recently started (dates) ____________

□ Since childhood (dates) ____________

□ Since the age of ___________years old

□ For about the last __________days/weeks/months/years

□ Following head injury, trauma, or motor vehicle accident which occurred on (date)___________

Location of headache:

□ Frontal (forehead) □ Parietal (side of head) □ Band-like (surrounding head)

□ Occipital (neck) □ Temple □ Orbital (around the eyes) □ Retro-orbital (behind the eyes)

Does headache occur on?

□ One side (right or left) □ Radiates from neck to forehead □ Both sides

□ Involves entire head □ Shifts from side to side □ Other ________________

Do you feel you have more than one type of headache: □ Yes □ No

If yes, ____

____

____

Frequency of headaches:

□ Daily □ Almost daily □ Intermittent throughout the day

□ Approximately how many times ___________per day/week/month/year (circle one)

Severity of head:

□ Mild □ Is the headache aggravated with bending over, walking, climbing stairs, or activity

□ Mild to moderate □ Do you have to lie down in a quiet dark room on occasions?

□ Moderate □ Lying down makes headache worse?

□ Moderate-severe □ Do you ever miss work/school because of headache?

□ Severe

Duration of headache:

□ Constant in nature

□ Last approximately _________ minutes/hours/days

□ Goes away in ______________minutes/hours if treated immediately with (name of medication) _______________________

Timing of headache:

□ Starts mild and progress to severe within ___________minutes/hours/days(circle one)

□ Severe at onset

Quality of headache: How would you best describe your headaches?

Please mark all that apply.

□ Band-like □ Sharp □ Dull achiness

□ Stabbing □ Constant headache □ Squeezing

□ Piercing □ throbbing □ Pinching

□ Vice-like □ Pounding □ Pressure

□ Pulsating □ Feels like head is going to explode

□ Feels like someone is squeezing your head □ Other____

Situation: Do the headaches awaken you from sleep? □Yes □ No

If yes, any special time after falling asleep:____

____

____

Prodrome: Do you notice any of the following symptoms 1-3 days prior to the onset of the headache?

□ Mood changes such as anxiety or depression □ Fatigue

□ Food craving □ Increased urination

□ Increased thirst □ Cervical stiffness or pain

□ Loss of appetite □ Other___________________________

Aura: Do you have vision changes that occur within 1 hour to the onset of the headache? □ Yes □No

If yes, do you see?

□ Spots □ Partial visual field loss □ Visual blurring

□ Illusions of distorted size/shape □ Simmering or wavy lines

□ Facial or upper extremity numbness and/or tingling □ Zig zag patterns

□ Flashes of light

Symptoms: Which symptoms accompany your headache?

□ None □ Nausea □ Lightheadedness/dizziness

□ Vomiting □ Slurred speech □ Difficulty with memory/concentration

□ Pacing □ Tenderness to temples □ Hair and/or scalp ache

□ Jaw tightness □ Nasal congestion □ Muscle achiness

□ Fever □ Diarrhea □ Neck tightness/stiffness

□ Tearing/watering of the eye on the affected side of the head

□ Sensitive to sound/noise (sonophobia) □ Sensitive to light/brightness (photophobia)

□ Vision problems (please explain)____

Headache precipitating factors/triggers: Do any of the following tend to bring on a headache?

A. Physical triggers

□ Brushing teeth	□ Loud noises
□ Coughing	□ Menstrual cycle
□ Eating/chewing/speaking	□ Physical activity
□ Exposure to glare	□ Sexual activity
□ Flickering lights	□ Too much sleep
□ Fluorescent lights	□ Too little sleep
□ Prolonged neck movement	□ Cigarette/cigar smoke

□ Other: ______________________________________

B. Food/Drink triggers

□ Alcohol	□ Chocolate
□ Bananas	□ Citrus fruit
□ Caffeine	□ Monosodium glutamate (MSG)
□ Cheese	□ Nuts

Headache precipitating factors/triggers: Do any of the following tend to bring on a headache?

C. Psychological Triggers

□ Family illness	□ Stress/tension
□ Personal illness	□ Marital status
□ Financial difficulties	□ Other__________________________

D. Seasonal/Allergy

□ Allergies to _______________	□ Scented candles
□ Exposure to cold/hot weather	□ Weather changes (rain/thunderstorms/etc)
□ High altitude	□ Food odors
□ High humidity	□ Perfume

□ Other ____

E. Occupation/work triggers

□ Chemical fumes (gas, oil, kerosene)	□ Prolonged computer usage
□ Chemical odor	□ Employment security (fear of being fired, lay-off
□ Repetitive movements	□ Work relationships/conflict

□ Other ____

Headache medication used in the past to alleviate the pain:

□ None	□ Eletriptan (relpax)
□ Butabitol	□ Frovatriptan
□ Cafergot	□ Imitrex tablets
□ Esgic Plus	□ Imitrex nasal spray
□ Fioricet	□ Imitrex injection
□ Fiorinal	□ Maxalt oral tablet
□ Phrenilin	□ Maxalt melt tablets (MLT)
□ Phrenilin Forte	□ Migranal nasal spray
□ Midrin	□ Zomig oral tablets
□ Stadol Nasal Spray	□ Zomig melt tablets (ZMT)
□ Axert	□ Zomig Nasal Spray
□ Amerge	□ Dihydroergotamine (DHE)

Did you ever take any medications on a daily basis to prevent or decrease the frequency/occurrence of headache?

□ Yes □ No If yes, please check all the daily medications taken in the past to prevent headaches.

Anticonvulsants	**Antidepressants**	**Antiemetics**	**Antihypertensives**
□ Depakote (ER)	□ Celexa	□ Compazine	□ Atenolol (Tenormin)
□ Keppra	□ Cymbalta	□ Phenergan	□ Corgard
□ Neurontin	□ Effexor (XR)	□ Reglan	□ Inderal (Propranolol)
□ Topamax	□ Elavil (Amitriptyline)	□ Tigan	□ Verapamil/Calan (SR)
□ Trileptal	□ Lexapro	□ Vistaril	□ Lopressor/Metoprolol/ Toprol XL
□ Lamictal	□ Nortriptyline		
□ Lyrica	□ Paxil (CR)		
□ Tegretol (XR)	□ Prozac		
□ Zonegran	□ Zoloft		
	□Wellbutrin (XL, SR)		

Anti-Inflammatory	**Narcotic Analgesic**	**Over the Counter**	**Muscle Relaxants**
□ Advil	□ Darvocet/Darvon	□ Advil Migraine	□ Flexeril
□ Aleve	□ Demerol	□ Excedrine	□ Robaxin
□ Anaprox (Naprosyn)	□ Dilaudid	□ Excedrine Migraine	□ Skelaxin
□ Bextra	□ Morphine	□ Ibuprofen Migraine	□ Soma
□ Celebrex	□ Percocet/Percodan	□ Tylenol	□ Zanaflex
□ Clinoril	□ Tylenol 2,3, & 4	□ Other______________	
□ Daypro	□ Vicodin		

……..Continued Anti-Inflammatory medication

□ Disalcid (Salsalate)

□ Diclofenac (Voltaren)

□ Feldene

□ Indocin

□ Medrol dose pack

□ Motrin (Ibuprofen)

□ Mobic

□ Prednisone

□ Ultram

□ Relafen

□ Vioxx

PAST MEDICAL HISTORY: Check all that apply □ None Apply

□ Abnormal heartbeat	□ Cirrhosis	□ High blood pressure	Neuropathy: □ Hands □ Feet
□ ADHD	□ Depression	□ High cholesterol	□ Poor circulation
□ Anemia	□ Down syndrome	□ HIV/AIDS	□ Seizure
□ Anxiety	□ Emphysema	□ Kidney failure	□ Spina bifida
□ Asthma	□ Gastric reflux	□ Kidney stones	□ Stomach ulcers
□ Bleeding disorder	□ Gout	□ Migraine	□ Stroke
□ Blood clots in leg	□ Heart attack	□ Multiple Sclerosis (MS)	□ Thyroid
□ Blood clots in lung	□ Heart failure	□ Neurofibromatosis	□ Tuberculosis
□ Cerebral palsy	□ Hepatitis B or C	□ Osteoporosis	□ Fibromyalgia
□ Osteoarthritis	□ Rheumatoid arthritis	□ Other Rheumatological Disease	

Cancer:____(type and treatment)

□ Diabetes: If yes, when was it diagnosed?____

Currently controlled with: □ Insulin □ Oral medication □ Diet

Other:____

PAST SURGICAL HISTORY: □ No prior surgery

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia? □ Yes □ No

If yes, have you had any problems related to this? □ Yes □ No

Explain any problems with general anesthesia:____

Social History: Work status

□ Working □ Homemaker □ Unemployed □ Disabled □ On leave □ Retired □ Student

Occupation: ____

Education: ____

Marital status: □ Single □ Married □ Divorced □ Widowed

Children: □ No □ Yes, how many? ________________

Do you live alone? □ Yes □ No If no, who lives with you?________________________________

Are you currently smoking? □ Yes □ No If yes, how many pack/day? __________For how many years? _________

Have you previously quit smoking? If so, when did you quit? __________How many years did you smoke? ____________

How many packs a day did you previously smoke? ___________Other forms of tobacco used? _____________________

Alcohol use: □ Never □ Rare □ Social □ Frequently (more than twice a week)

□ Alcoholic □ Recovering alcoholic

Illegal drug use:□ Never □ In the past □ Currently □ Types of drugs? ____________________________

Do you drink caffeine? □ Yes □ No How much? ____

Sexually active: □ Yes □ No

FAMILY HISTORY: Please fill in the illness information below with the options listed:

Alcoholism	Cancer	High blood pressure	Other Rheumatological Disease
Arthritis	Diabetes	Kidney problems	Seizure
Bleeding problems	Gout	Lung problems	Stroke
Blood clots	Heart problems	Mental Illness	Other

FAMILY MEMBER	ILLNESS	AGE	IF DECEASED, AGE AT DEATH AND CAUSE
Father			
Mother			
Brother(s)			
Sisters			
Children			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Paternal Uncle			
Paternal Aunt			
Maternal Uncle			
Maternal Aunt			

Family History Unknown □ Adopted □

Please rate your usual level of pain on the following scale (circle one):
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst imaginable pain)

Patient's signature: ____

Provider signature: ____

Date: ____

Date: ____