Park Nicollet
HealthPartners

Date Completed: _______________

Name: ________________________________

Date of Birth: ____________________________

Daytime Phone #:

HEADACHE History:

On average you have headache how many **days/month**? ____
On average how many **days/month** is pain **moderate or severe**? ____
If you take an **acute pain drug** for your headaches how many **days/month**? ____
Do headaches start so quickly they reach maximum in < 2 minutes and then persist? ☐ No ☐ Yes
Have headaches occurred only a certain time of day or been dependent on your body position? ☐ No ☐ Yes
Is current headache different than in the past? ☐ No ☐ Yes If yes, how?________________________________

_____ 1. How many days in the last 3 months did you miss work or school because of your headaches?
_____ 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.)
_____ 3. How many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?
_____ 4. How many days in the last 3 months was your productivity in household work reduced by half or more? (Do not include days you counted in question 3 where you did not do household work.)
_____ 5. How many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

Headache Description (if needing to describe additional headaches use back of form or additional paper):

Headache Type **You call your headache or consider the cause to be?**	Type #1 _____________	Type #2 _____________	Type #3 _____________
How bad does this headache pain usually get: 1 = mild; 2 = moderate; 3 = severe/unbearable	1 2 3	1 2 3	1 2 3
When or at what age did you first get this headache?			
How many mins, hrs, days or wks does your pain usually last?	____ minutes ____ hours ____ days ____ weeks	____ minutes ____ hours ____ days ____ weeks	____ minutes ____ hours ____ days ____ weeks
Where does your head hurt? (Check all that apply)	☐ Left side ☐ Right side ☐ All over ☐ Variable ☐ Front,forehead ☐ Eye ☐ Back or near the neck ☐ Top of head ☐ Face,jaw	☐ Left side ☐ Right side ☐ All over ☐ Variable ☐ Front,forehead ☐Eye ☐ Back or near the neck ☐ Top of head ☐ Face,jaw	☐ Left side ☐ Right side ☐ All over ☐ Variable ☐ Front,forehead ☐ Eye ☐ Back or near the neck ☐ Top of head ☐ Face,jaw
How does the pain feel? (Check all that apply)	☐ Sharp/Stabbing ☐ Burning ☐ Dull ache/Pressure/Viselike ☐ Throbbing/ Pounding	☐ Sharp/Stabbing ☐ Burning ☐ Dull ache/Pressure/Viselike ☐ Throbbing/ Pounding	☐ Sharp/Stabbing ☐ Burning ☐ Dull ache/Pressure/Viselike ☐ Throbbing/ Pounding
Does this pain get worse with activity such as climbing stairs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
What other symptoms do you get with this headache? (Check all that apply)	☐ None ☐ Light sensitivity ☐ Noise sensitivity ☐ Smell sensitivity ☐ Nausea or no appetite ☐ I vomit ☐ I have difficulty thinking ☐ I feel dizzy; I spin ☐ Tearing/Nasal Congestion ☐ I am sensitive to hot or cold ☐ Skin touch causes pain Other:	☐ None ☐ Light sensitivity ☐ Noise sensitivity ☐ Smell sensitivity ☐ Nausea or no appetite ☐ I vomit ☐ I have difficulty thinking ☐ I feel dizzy; I spin ☐ Tearing/Nasal Congestion ☐ I am sensitive to hot or cold ☐ Skin touch causes pain Other:	☐ None ☐ Light sensitivity ☐ Noise sensitivity ☐ Smell sensitivity ☐ Nausea or no appetite ☐ I vomit ☐ I have difficulty thinking ☐ I feel dizzy; I spin ☐ Tearing/Nasal Congestion ☐ I am sensitive to hot or cold ☐ Skin touch causes pain Other:
Do you have any visual changes (zigzag lines, flashing lights, tunnel vision) with this headache?	☐ Yes ☐ No Circle or write changes below:	☐ Yes ☐ No Circle or write changes below:	☐ Yes ☐ No Circle or write changes below:

Please check any of the following you feel may start or trigger your headaches (Check all that apply): Alcohol ☐; Fasting ☐; Foods (list): _____ ☐; Odors ☐; Bright light ☐; Sun ☐; Altitude changes ☐; Seasonal changes ☐; Weather changes ☐; Clenching my jaw ☐; Sore jaw muscles ☐; Grinding teeth ☐; Too much sleep ☐; Changes in usual sleep pattern ☐; Lack of sleep ☐; Restless legs ☐; Exertion (such as climbing up stairs) ☐; Stress ☐; Vacations ☐; Weekends ☐; Let-down periods (following a big event) ☐; Allergies or sinus problems ☐; Hormones ☐; Menstrual periods ☐.
How often do you think you know what triggered your headache? ☐ <25% ☐ 25 – 50% ☐ 50 – 75% ☐ 75 – 100%

Your Family History:
Any family history of headaches? ☐ No ☐ Yes If yes, who? _____
Any family history of nervous system problems such as ☐depression, ☐anxiety? If yes, who?_____

Your Medical History:
Motor vehicle accident(s): ☐ No ☐ Yes Year(s) _____Injuries: ☐ No ☐ Yes Headache changes: ☐ No ☐ Yes
Litigation over the MVA? ☐ No ☐ Yes. Are you on disability for any reason? ☐No ☐Yes

Social-Psychological History:
My marital status: ☐Single ☐Married (☐first ☐second) ☐Significant Other ☐Divorced ☐Widowed
Number of children I have? ___ Ages _____
My occupation: _____ # years: _____ # hours per week:_____
The most important stressors in my life are:_____
I have/or had ☐depression ☐anxiety ☐post-traumatic stress ☐Abuse: sexual, physical, emotional
Suicidal thoughts: Never had ☐; Currently have ☐; Have had in the past but don't now ☐
Lifestyle:
How many hours of sleep per night? _____ Is sleep disturbed? ☐ No ☐ Yes **If yes, describe_____**
Do you have difficulty falling asleep, teeth clenching or snoring? ☐ No ☐ Yes
How many days/week do you practice any relaxation techniques? _____ Describe_____
How many drinks/cups per day of a caffeinated beverage do you consume? _____
Do you have any artificial sweeteners-aspartame, sucralose and truvia/stevia. ☐ No ☐ Yes Do you use Sudafed, Actifed, Pseudoephedrine, Claritin D, etc.? ☐ No ☐ Yes
How many meals do you eat per day? _____ Are these regular meals without skipping? ☐ No ☐ Yes
How many days per week do you exercise? _____If so, what type and for how long_____
How many ounces of fluid do you drink per day? _____ What do you drink? _____
Substance Use:
Do you use tobacco? ☐ No ☐ Yes If yes, how many packs per day? _____ For how long? _____
Do you use alcohol? ☐ No ☐ Yes - how many drinks per week? _____ Do you use marijuana or other? ☐ No ☐ Yes

Check all daily preventative medications you have taken before for headache (Obtain your pharmacy records for use):

☐Elavil – amitriptyline	☐Tenormin – atenolol	☐Depakote – valproic acid
☐Pamelor – nortriptyline	☐Inderal – propranolol	☐Lamictal – lamotrigine
☐Norpramin – despiramine	☐Lopressor – metoprolol	☐Lyrica – pregabalin
☐Cymbalta – duloxetine	☐Calan –verapamil	☐Neurontin – gabapentin
☐Deseryl – trazodone	☐Cardizem diltiazem	☐Topamax – topiramate
☐Effexor – venlafaxine	☐Norvasc – amlodipine	☐Zonegran – zonisamide
☐Paxil – paroxetine	☐Indocin – indomethacin	☐CoEnzyme Q10
☐Prozac – fluoxetine	☐Magnesium	☐Namenda – memantine
☐Wellbutrin – bupropion	☐Petadolex – butterbur	☐Diamox – acetazolamide
☐Zoloft – sertraline	☐Vitamin B2 – riboflavin	☐Botox A

Check all acute pain meds you have taken before for headache (Use your pharmacy records if available):

☐**Aspirin**	☐Amerge – naratriptan	☐Prednisone
☐**Tylenol – acetaminophen**	☐Axert – Almotriptan	☐Medrol dose pack
☐**Advil – ibuprofen**	☐Frova – frovatriptan	☐Reglan – metoclopramide
☐**Excedrin Migraine**	☐Imitrex – sumatriptan	☐Zofran
☐**Indocin indomethacin**	☐Maxalt/MLT – rizatriptan	☐Phenergan
☐**Aleve/Naproxen**	☐Relpax – eletriptan	☐Compazine – Prochlorperazine
☐**Toradol – ketorolac**	☐Zomig/ZMT – zolmatriptan	☐Lidocaine nose drops
☐Cafergot – ergotamine	☐Migranal NS – DHE NS	☐Stadol NS – butorphanol
☐**Midrin – isomethetpene**	☐DHE- 45	☐**Fioricet/Fiorinal/bultalbital**

☐ Muscle relaxers: _____ ☐Pain medications/Opioids:_____

OTHER:_____

Previous Headache Care:

Please list all physicians you have seen for Headache Care, and Testing (example: MRI brain, CT head, etc). If records are outside of Park Nicollet, Health Partners, Fairview, Allina please request those records be faxed to 952-993-5063 or hand carry to appointment if needed due to timing.

Complete Review of Systems History

Please check all symptoms that apply to you **within the past month**:

REVIEW OF SYSTEMS – CHECK BOX as Appropriate:

	Present	Present
GENERAL HEALTH	☐ Chills ☐ Fever ☐ Sweats	☐ Malaise ☐ Fatigue ☐ Weight change
EYES	☐ Visual acuity ☐ Redness	☐ Holes in vision
ENT	☐ Double vision ☐ Sore throat ☐ Nose Bleeds ☐ Nose drainage	☐ Tooth pain ☐ Earache ☐ Hearing loss ☐ Vertigo (Spinning or Sense of Motion)
BREATHING	☐ Cough ☐ Wheezing	☐ Sputum ☐ Cough Up Blood
HEART	☐ Chest pain ☐ Extra heart beats ☐ Faint/syncope ☐ Snores	☐ Shortness of Breath When Lying Down ☐ Swelling in the Feet or Legs ☐ Inflammation in a Vein(s)
GI/BOWELS	☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Constipation	☐ Blood in Sputum ☐ Trouble Swallowing ☐ Yellow Eyes or Skin (Jaundice)
GENITALS/ URINE	☐ Frequency ☐ Urgency ☐ Pain with Urination ☐ Incontinence	☐ Blood in Urine Last Menstrual Period:_____ ☐ Vaginal discharge ☐ Painful Menstrual Periods ☐ Testicle Pain/Swelling
MUSCLES/BONES	☐ Joint Pain ☐ Joint Swelling ☐ Muscle Pain	☐ Range Of Motion Limitation ☐ Falls
SKIN	☐ Rash ☐ Lesions/Sores	☐ Itching
NERVOUS SYSTEM	☐ Altered or LOC ☐ Tingling ☐ Weakness/Paralysed	☐ Tremor ☐ Seizure ☐ Memory problems
MENTAL HEALTH	☐ Anxiety ☐ Depression	☐ Insomnia ☐ Hallucination
ENDOCRINE	☐ Frequent Drinking ☐ ↑ Urine Volume	☐ Frequent Eating ☐ Hot or Cold intolerance.
BLOOD SYSTEM	☐ Anemia ☐ Enlarged Lymph Nodes	☐ Bruising/Bleeding
ALLERGY	☐ Dermatitis ☐ Hives ☐ Runny Nose	☐ Pollens, dander ☐ Previous PPD positive (TB test) ☐ Previous positive skin tests