

MD NEW PATIENT HISTORY

HEADACHE INSTITUTE OF TEXAS

PATIENT IDENTIFICATION

LAST NAME _____ FIRST NAME _____ MI _____
 DATE OF BIRTH _____ SEX M / F SSN _____ DATE _____

HEAD AND NECK INJURY HISTORY:

Have you ever injured your head or neck? Think of any events that might have whipped your head around on your neck, both as a **child** and as an **adult**. For example, have you ever: fallen off of a bike or swing; twisted you neck in gymnastics, sports, cheerleading; had a car accident, fall, blow to the head, or other neck injury?

TYPE OF INJURY	APPROXIMATE DATE OF INJURY

ALLERGIES (Please Check what you are allergic to and the reaction that you had):

- ___ Aspirin
- ___ Codeine
- ___ Erythromycin
- ___ Morphine
- ___ Penicillin
- ___ Sulpha Meds
- ___ X-Ray Dye
- ___ Injections
- ___ Other Medications
- ___ Other (Food, etc.)

RASH	HIVES	SWELLING OF LIPS/ TONGUE/ AIRWAYS	SHORT OF BREATH	STOMACHE UPSET	OTHER

STUDIES

Have you had any of the following for your headache symptoms?

MRI/MRA of Brain?	Y	N	When? _____
MRI/X-Ray of Neck?	Y	N	When? _____
EMG (nerve conduction study)?	Y	N	When? _____
MRI/MRA of Sinuses?	Y	N	When? _____

MEDICATIONS (List names, strength and doses of all current medications, both prescription and over the counter):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

ASSOCIATED SYMPTOMS: Please put a check mark next to any of the following symptoms that you have experienced with this problem (currently or in the past). Please specify whether the symptoms occur WITH headaches, WITHOUT headaches or BOTH.

	Occurs WITH headache	Occurs WITHOUT headache	Occurs with AND without
Sensitivity to sound	_____	_____	_____
Ears ringing or buzzing.	_____	_____	_____
Ear fullness or pain.	_____	_____	_____
Dizziness or lightheadness.	_____	_____	_____
Nausea or vomiting.	_____	_____	_____
Cold or clammy hands.	_____	_____	_____
Sweating for no apparent reason.	_____	_____	_____
Eyes are sensitive to light.	_____	_____	_____
"Lights, spots or holes" in field of vision.	_____	_____	_____
Cheek or sinus pressure.	_____	_____	_____
Jaw tightness or pain.	_____	_____	_____
Teeth clenching or grinding.	_____	_____	_____
Pain in teeth.	_____	_____	_____
Numbness or weakness anywhere in body	_____	_____	_____
<i>One side of body</i> is numb or weak.	_____	_____	_____
Reflux or heartburn symptoms.	_____	_____	_____
Irritable bowel symptoms:	_____	_____	_____
(Abdominal pain, diarrhea, constipation)			

HEADACHE MEDICATION HISTORY

Circle any drugs previously used, approximate date of use, and effect of medication on pain relief:

TRIPTANS:

- Amerge _____
- Axert _____
- Frova _____
- Imitrex _____
- Maxalt _____
- Relpax _____
- Zomig _____

NSAIDS:

- Acetaminophen _____
- Aspirin _____
- Advil (Motrin, Ibuprofen) _____
- Naproxen _____

NARCOTIC ANALGESICS:

- Demerol _____
- Dilaudid _____
- Lortab _____
- Tylenol No. 3 _____
- Vicodin _____
- Stadol nasal spray _____

ERGOT DERIVATIVES:

- Cafergot _____
- Migranal _____
- Sansert _____

BETA BLOCKERS:

- Propranolol _____
- Timolol _____
- Inderal _____
- Other _____

ANTIPILEPTIC AGENTS:

- Depakote (divalproex sodium) _____
- Depakene (valproic acid) _____
- Keppra _____
- Neurontin (gabapentin) _____
- Topamax _____
- Lyrica _____
- Other _____

CALCIUM CHANNEL BLOCKERS:

- Verapamil _____

BARBITURATES:

- Butalbital _____
- Esgic-Plus _____
- Fioricet _____
- Fiorinal _____
- Phrenilin _____

TRICYCLICS:

- Amitriptyline (Elavil) _____
- Desipramine _____
- Imipramine _____
- Nortriptyline _____

SLEEP AIDES:

- Ambien _____
- Lunesta _____
- Melatonin _____
- Sonata _____
- Other _____

MUSCLE RELAXANTS:

- Flexeril _____
- Skelaxin _____
- Robaxin _____
- Soma Compound _____
- Zanaflex _____

ANTI-ANXIETY:

- Alprazolam (Xanax) _____
- Buspar _____
- Klonopin _____
- Librium _____
- Serax _____
- Tranxene _____
- Valium _____

ANTIDEPRESSANTS (non-tricyclics)

- Buspar _____
- Celexa _____
- Cymbalta _____
- Effexor _____
- Lexapro _____
- Paxil _____
- Prozac _____
- Wellbutrin _____
- Zoloft _____
- Other _____

OTHER:

- Midrin _____
- Steroids _____
- Occipital Nerve Block _____
- Botox Injections _____
- Lithium _____
- Intranasal Lidocaine _____
- Epidural steroid injections _____

PAST PERSONAL MEDICAL HISTORY (Check and note if/when you have had):

<u>YES</u>	<u>WHEN</u>	<u>YES</u>	<u>WHEN</u>
_____	Heart Problems_____	_____	Cancer_____
_____	High Blood Pressure_____	_____	Epilepsy/Seizures_____
_____	High Cholesterol_____	_____	Stroke_____
_____	Asthma_____	_____	Diabetes_____
_____	Emphysema_____	_____	Thyroid Problems_____
_____	Bronchitis_____	_____	Osteoarthritis_____
_____	Allergies/Hay fever_____	_____	Rheumatoid Arthritis_____
_____	Pneumonia_____	_____	Lupus_____
_____	Depression_____	_____	Fibromyalgia_____
_____	Suicide Attempt_____	_____	Irritable Bowl Syndrome_____
_____	Anxiety_____	_____	Spastic Colon_____
_____	Panic Attacks_____	_____	Colitis_____
_____	Alcoholism_____	_____	Yellow Jaundice_____
_____	Problems Controlling Anger_____	_____	Stomach Ulcers_____
_____	Violent Behavior_____	_____	Heartburn/Indigestion/Reflux_____
_____	Kidney Disease_____	_____	Constipation_____
_____	Hepatitis_____	_____	Anemia_____
_____	AIDS_____	_____	Bleeding Problems_____
_____	STD's_____	_____	Blood Transfusions_____
_____	Rheumatic Fever_____	_____	Cataracts_____
_____	Mumps_____	_____	Head/Neck Injury_____
_____	Measles_____	_____	Concussion_____
_____	Polio/Tuberculosis_____		

_____ Other Significant Illnesses or Injuries (please list):_____

SURGICAL HISTORY (Check and note if/when you have had):

<u>YES</u>	<u>WHEN</u>	<u>YES</u>	<u>WHEN</u>
_____	Neck_____	_____	Cataracts_____
_____	Back_____	_____	Tonsillectomy_____
_____	Joints_____	_____	Breast_____
_____	Fractures_____	_____	Caesarian Section_____
_____	Hernia_____	_____	Hysterectomy_____
_____	Vasectomy_____	_____	Tubal Ligation (Tubes tied)_____
_____	Prostate_____	_____	Sinus Surgery_____
_____	Appendectomy_____	_____	Hemorrhoids_____
_____	Gallbladder_____		

Any other surgeries not listed: _____

SOCIAL HISTORY:

Habits:

- Do you drink coffee, tea, colas or eat chocolate? Y____ N____ #cups/glasses/amount per day_____
- Do you currently smoke? Y____ N____ # Cigarettes per day_____ # of years smoked_____
- Have you smoked in the past? Y____ N____ #Cigarettes per day_____ #of years smoked_____
- When did you quit smoking?_____
- How much alcohol do you drink per week on average?_____
- How many hours of sleep per night do you get on average?_____
- Do you exercise? Y____ N____ Type?_____
- How often: Min/day:_____ Days/week:_____

Your Occupation: _____

Average number of hours worked per week: _____

Marital Status: _____Never Married _____Married _____Divorced _____Separated _____Widowed

Spouse Information:

- Name:_____
- Occupation:_____
- Average number of hours worked per week:_____
- Health Problems:_____

Household Members: List the names and relationship to you (i.e. child, spouse, mother, friend) of the people who live in your home.

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

Who does most of the housework_____, laundry_____, cooking_____, shopping_____.

Education: (Check the highest level attended)

- | | |
|----------------------|------------------|
| _____Grade School | _____Junior High |
| _____High School | _____College |
| _____Graduate School | _____Other:_____ |

Hobbies/Interests: _____

REVIEW OF SYSTEMS

INSTRUCTIONS: As you review the following list, please check any of those problems that have been major concerns for you over the last year.

General:

- Unintentional weight gain
- Unintentional weight loss
- Fever, chills, night sweats
- Fatigue

Eyes:

- Pain
- Redness
- Loss of vision
- Double vision
- Blurred vision
- Dry eyes
- Feels like something in the eye

Ears:

- Ringing in the ears
- Hearing loss
- Stuffy ears
- Dizziness
- Ear pain

Nose:

- Nosebleeds
- Loss of smell
- Nasal dryness
- Nasal congestion or stuffiness
- Postnasal drainage

Throat/Mouth:

- Frequent sore throat
- Hoarseness
- Difficulty swallowing
- Snoring
- Bleeding gums
- Sores in mouth
- Dryness

Allergic/Infectious/Immunologic:

- Hives
- Sneezing

Cardiovascular:

- Chest pain
- Irregular heartbeat
- Fast or slow heart beat
- Shortness of breath
- Difficulty breathing at night
- Shortness of breath on exertion
- Swollen legs or feet
- Heart murmur
- Blacking out or fainting

Lungs:

- Cough
- Shortness of breath
- Wheezing
- Coughing up blood
- Coughing up sputum on a regular basis

Stomach and Intestines:

- Abdominal pain
- Nausea or vomiting
- Heartburn or indigestion
- Vomiting blood or coffee-ground material
- Jaundice (turning yellow)
- Constipation
- Diarrhea
- Blood in stools
- Black stools
- Difficulty swallowing
- Painful swallowing
- History of Irritable Bowel Syndrome

REVIEW OF SYSTEMS (Continued)

Kidney/Bladder/Genital:

- Burning with urination
- Blood in urine
- Urinating very frequently
- Getting up at night to urinate
- Frequent bladder infections
- Vaginal or penile discharge
- Vaginal dryness
- Genital rashes, sores or ulcers
- Sexual difficulties
- Prostate trouble

Endocrine:

- Urinating very frequently
- Feeling excessively thirsty
- Excessive fatigue
- Heat or cold intolerance

Skin:

- Rashes
- Sun sensitivity
- Tightness
- Bumps
- Hair loss
- Color changes of hands or feet
In the cold
- Changes in moles
- Sweaty hands

MSK:

- Joint pain
- Morning stiffness
- Muscle weakness
- Muscle tenderness
- Joint swelling

Hematologic/Lymphatic:

- Anemia
- Easy bruising
- Easy bleeding
- Swollen glands in neck, armpits,
groin

Psychiatric:

- Poor sleep
- Diminished interest/motivation
- Excessive guilty thoughts
- Decreased energy
- Decreased concentration
- Change in appetite
- Feeling like life isn't worth living
- Suicidal thoughts
- Depressed mood
- Anxiety
- Irritability

Neurological:

- Problem swallowing or speaking
- Double vision
- Tremor or shakiness
- Loss of hearing
- Change or loss of taste or smell
- Difficulty walking
- Weakness
- Ringing in the ears
- Memory problems