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):

	RASH	HIVES	SWELLING OF LIPS/ TONGUE/ AIRWAYS	SHORT OF BREATH	STOMACHE UPSET	OTHER
• ___ Aspirin						
• ___Codeine						
• ___Erythromycin						
• ___Morphine						
• ___Penicillin						
• ___Sulpha Meds						
• ___X-Ray Dye						
• ___Injections						
• ___Other Medications						
• ___Other (Food, etc.)						

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	_____	_____	_____
***One side of body** 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________________

ANTIEPILEPTIC 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):

YES		WHEN	YES		WHEN
____	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):

YES		WHEN	YES		WHEN
____	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: ____

FAMILY MEDICAL HISTORY:

RELATION	AGE	HEALTH PROBLEMS	CAUSE OF DEATH	AGE AT DEATH
FATHER				
MOTHER				
BROTHER				
BROTHER				
BROTHER				
SISTER				
SISTER				
SISTER				
CHILD				
CHILD				
CHILD				

Have **YOU** or any of **YOUR BLOOD RELATIVES** (i.e. parents, brothers, sisters, aunts, uncles, cousins grandparents) been affected by any of the following issues?

YES **WHEN / WHO**

_____Heart Attack___________________________________
_____Heart Failure___________________________________
_____High Blood Pressure______________________________
_____Brain Aneurysms_______________________________
_____Epilepsy/Seizures_______________________________
_____Stroke_______________________________________
_____Asthma_______________________________________
_____Emphysema____________________________________
_____Bronchitis_____________________________________
_____Tuberculosis___________________________________
_____Osteoarthritis__________________________________
_____Rheumatoid Arthritis____________________________
_____Lupus____
_____Fibromyalgia___________________________________
_____Brain Tumor____________________________________
_____Cancer_______________________________________

YES **WHEN / WHO**

_____Diabetes_______________________________________
_____Thyroid Problems________________________________
_____Problems Controlling Anger________________________
_____Violent Behavior_________________________________
_____Depression_____________________________________
_____Suicide____
_____Anxiety____
_____Alcoholism_____________________________________
_____Physical Abuse__________________________________
_____Sexual Abuse___________________________________
_____Emotional Abuse_________________________________
_____Assault____
_____Murder____
_____Abortion_______________________________________

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