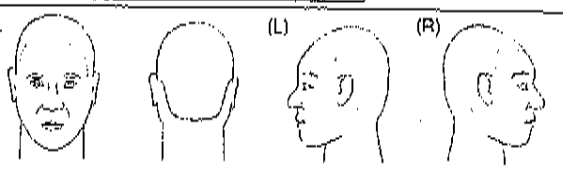
HEADACHE HISTORY & PROFILE

NAME DATE OF BIRTH DATE

Formedic

On what part of the head do the headaches start? Use diagrams to indicate -



(R) Side (L) Side Either side Both sides

Back On top Temples Behind / around eyes

Forehead Face Neck Other -

After the headache starts – Does it usually – Stay in one place Move around Please explain -

How would you describe the pain? - Throbbing / pulsating Pressing / squeezing Stabbing Sharp

Dull / nagging Other -

Describe the degree of pain (circle one #) - slight - 1 2 3 4 5 6 7 8 9 10 - worst imaginable

Do your headaches interfere or prevent normal activities - work etc.? No Yes

How long ago did the current headaches start? Weeks Months Years

How old were you when any headache started?

How long does the headache usually last? Minutes Hours Days Constant

How often does the headache occur? x / Day x / Week x / Month x / Year Constant

Does the headache awaken you from sleep? Yes No

Is the headache getting worse better fluctuating no change

Are any of the following symptoms associated with the headache? Please mark (B) before (✓) during (A) after

Spots before eyes - type -
Blindness (R L)
Blurring (R L)
Double vision
Can see only half of objects
Eyelid droop (R L)
Tearing (R L)
Eye redness (R L)
Eyes puffy (R L)
Light sensitivity
Noise sensitivity
Odors sensitivity
Nose blocked / discharge (R L)

Nausea Vomiting
Loss of appetite Hunger
Cramps Diarrhea

Face - Scalp -

Pale Redness
Sweating Tender
Puffy Pain on chewing
Decreased jaw opening

Neck -

Stiff Tender
Difficulty concentrating
Depression Anxiety
Fatigue Irritability

Weakness(W) Numbness(N) Both(B)

Face (R L) Arms (R L)
Arm & leg (R L) Legs (R L)
Difficulty talking (finding words)
Difficulty understanding
Numbness around lips
Slurred speech
Fainting (feel like or have fainted)
Dizzy (lightheaded - unsteady - spinning)

Hands and / or feet -

Cold Pale
Sweaty Mottled

HEADACHE HISTORY & PROFILE (continued) Formedic

Indicate if any of the following factors have (✓) brought on (trigger) or (x) worsen your headache –

Head injury	Sexual activity	Other foods
Sleep - too much - too little	Missed meal	
Emotional stress during after	Change in weather	
Depression - anxiety	Seasons -	Medications
Physical activity	Alcohol MSG	
Erect position	Processed meats	Menstrual periods
Bending over	Chocolate Citrus fruits	Pregnancy Menopause
Straining - coughing	Cheeses	Contraceptives

Do any blood relatives have severe headaches? ☐ No ☐ Yes – Who & Diagnosis –

Which of the following makes the headache better? Rest Activity Darkness Quiet Compresses
Scalp or temple pressure Pregnancy Menopause

Social history - Cigarettes (#day / #yrs.) Alcohol (oz. / day) Coffee (cups / day)

Are you or have you been - Depressed Anxious

Previous professional treatment of headache? ☐ No ☐ Yes – Who & When –

Previous x-ray or other investigations of headache? ☐ No ☐ Yes – Describe –

Previous medications for headache? ☐ No ☐ Yes Name – dosage

Other current medications? Please list – include over the counter drugs

DRUG ALLERGIES

ADDITIONAL NOTES