HEADACHE HISTORY

Headache patients are not all the same, so in order to ensure we can provide as accurate a diagnosis as we can, and the most appropriate recommendations for testing and treatment as possible, as quickly as possible, we would ask your assistance in filling out the following forms as completely and accurately as possible.

Not all questions may pertain to you. The more complete information you provide on these forms prior to your appointment the better we can design your plan of care and thus optimize your time at your initial appointment. If you have questions, please contact us so we can assist you. As this is an extensive amount of information, it is not generally recommended to wait until you arrive at the office to begin the process of filling out the headache history.

These forms are in addition to the basic forms all new patients are asked to complete, as these are only concerned with the symptom of headache.

We appreciate your time in providing us an accurate, complete record of your headache history so we can be better prepared to help you!

Thank you!

Frisco Spine
At what age did you first start having headaches? _______________________________

Does anyone else in your family have headaches? Y N Who? _______________________

How long was the longest headache you’ve had (treated or untreated)? _______________

What is the longest period of time you have not had a headache for? ________________

Currently, do you have a headache all of the time? Yes No

If so, how long have you “kept” this headache”? ________________________________

Does it feel like your “typical” headache or is this one different? ________________

Did this change from having episodic headaches occur suddenly or gradually? _______

If your headache isn’t there all the time, over the last six (6) months please estimate on how
many days per month you have had a headache. _________________________________

Is your headache problem getting worse? Yes No

Is it becoming more frequent, more severe, lasting longer? _______________________

If your headache problem has changed, when exactly did that occur? ________________

Please list if something occurred prior to this change in your headaches (e.g., an illness, an
accident, a significant emotional event). __________________________________________

Do you go to the emergency room/acute care facility for headache? Yes No

Have you ever been admitted to the hospital to treat your headache? Yes No

Have you ever seen a headache specialist? Yes No Who? ________________________

Do your headaches appear to be more prominent or only occur at certain times of the year?

Do your headaches seem to occur at certain times of the day? ____________________
Do headaches wake you up in the middle of the night?  Yes  No

Do you commonly wake up at your normal time in the morning with a headache?  Yes  No

How long does it take for your headache to reach how bad it is going to get (in other words, how long is the build-up time for the pain) if you don’t take any medication?  ___________________

Where on your head does your headache typically start?  ________________________________

When fully developed, what part of the head is then involved in the pain?  __________________

How bad is the pain typically? 0 is no pain, 10 is the worst pain imaginable?  _______________

Untreated, how long does the headache typically last?  _________________________________

What is the best way to describe the type of pain that the headache is?  ________________________________

Does the pain you have with the headache throb?  Yes  No

Are there any particular triggers which seem to provoke your having a headache?

**Foods:**
- tyramine (found in chocolate; aged cheeses; vinegar; organ meats; sour cream; soy sauce; yogurt; yeast extracts)
- nitrites (found in smoked fish; pepperoni; hot dogs; bologna; bacon; corned beef; pastrami; canned ham; sausages)
- sulfites; phenylethylalanine; tannins
- MSG (found in dry roasted nuts; potato chips; Chinese food; processed or frozen food; soups and sauces; diet foods; salad dressings; and mayonnaise)
- dehydration, fasting, or skipping meals
- alcohol (red wine; brandy; least likely—scotch, vodka, and Rieslings)
- vitamins (A and B, esp. niacin)
- caffeine or not enough caffeine
- dairy products
- soy beans
- wheat products
- onions
- fatty foods
- seafood
- aspartame (Nutrasweet) or other artificial sweeteners
- beans; chiles; licorice; fried foods; peanuts; popcorn; nuts/seeds
Hormones:
- onset of your menstruation
- menstrual periods (or before they start)
- time of ovulation (generally two weeks before your period)
- use of hormones/birth control pills
- pregnancy or after pregnancy
- menopause/perimenopause

Changes:
- weather
- barometric pressure
- seasons
- travel, especially across time zones
- altitude
- schedule changes
- sleeping patterns
- oversleeping
- under sleeping
- skipping meals
- fatigue
- riding in a car
- vacations

Sensory stimuli:
- strong lights
- glare
- flickering lights
- strong smells
- head jarring
- hunger
- position
- sexual activity
- sneezing
- straining
- stress (or after done with the stress)
- touching
- bending over
- chewing
- coughing
- loud noises
- reading in a car
- eating cold foods/drinks ("ice cream headache")
- lack of caffeine
Allergies or sinusitis

Stress:
- intense emotional stress
- intense exercise
- changes in stress levels
- periods after stress has resolved
- relationship problems
- work-related problems

Is there anything you can do to make your headache less severe? _________________________

Is there anything you can do to make you headache go away? ___________________________

Can you sleep off your headaches? Yes No

What do you typically do when you have a headache, especially a severe one? ______________
______________________________________________________________________________

Some patients can have symptoms which lead them to know that they’re going to get a headache in a day or so, or their close family or coworkers notice these and tell them so. Do you (or have others told you that you) have any of the below symptoms which could predict your having a headache in the next day or so:

- mental slowness
- depression
- hyperactivity
- fatigue
- euphoria
- talkativeness
- irritability
- drowsiness
- malaise/feeling bad
- restlessness
- surge of energy
- light sensitivity
- poor concentration
- smell sensitivity
- sound sensitivity
- problems talking
- sleep too much
- yawning
- muscle aches
- hot ears
- stiff neck
- food cravings
- cold feelings
- loss/increase of appetite
- sluggishness
- diarrhea
- constipation
- nose bleed
- thirst
- urination
- fluid retention
Just before having a headache, within a few hours of the head pain’s starting, do you have any symptoms such as:

visual loss or changes  seeing dots  seeing zigzag lines
numbness  dizziness  tunnel vision
tingling  language problems  emotional changes
tunnel vision  lightheadedness  inspiration or other religious experience
vertigo  hearing issues  change/loss of taste
change/loss of smell  things look too small  touch sensitivity
things look too large  tongue numbness  lips numb/tingling

If so, do they stop before the headache starts or do they continue through into the headache? _______________________________

If they stop prior to the head pain, how long do these symptoms last before the head pain starts? _______________________________

For visual symptoms, do you have them without ever developing the headache? Yes No

During the actual head pain itself, do you have any of the below symptoms:

loss of appetite  nausea with or w/o vomiting  smell sensitivity
light and/or sound sensitivity  lightheadedness  clumsiness
mood changes  visual blurring  vertigo
concentration difficulties  excess hot or cold feelings  tremors
diarrhea  fluid retention  slurred speech
feeling need to have a BM  constipation  pale
abdominal cramps  feeling poorly  double vision
cold hands/feet  loss of appetite  weakness
nasal congestion/drainage  fever/chills  excess urination
runny eyes  facial flushing  teeth grinding
change in pupil size  scalp tenderness  fatigue
red eyes  lack of coordination  insomnia
eyelid swelling  irritability  visual loss
droopy eyelid  loss of depth perception  passing out
facial swelling  uncontrolled bowels  uncontrolled bladder
amnesia  neck pain/tenderness  language problems
blindness  confusion  shoulder stiffness
problems talking  ear ringing  hearing loss
numbness  tingling  “spacey” feeling
neck tenderness  goose bumps
Does the headache get worse with bending over, climbing stairs, walking?  
Yes  No

Does having a headache keep you from doing your normal daily activities, working, or prevent you from doing enjoyable activities?  
Yes ____________________________________________ No

When you don’t have a headache, do you have:
spots or dots or temporary visual loss on standing up quickly  
Yes  No
excessive blurry vision  
Yes  No
double vision  
Yes  No
ringing in your ears (and does it throb with your pulse if you have it)  
Yes  No
recent weight gain  
Yes  No

Do you have any of the following symptoms as new symptoms?

does your headache come on or worsen dramatically on standing or sitting?  
Yes  No
does your headache start on getting out of bed and then worsen throughout the day?  
Yes  No
can you have little to no headache in the morning but every afternoon you develop a severe one?  
Yes  No
do you have any fluid leaking out of your ears or nose?  
Yes  No
do you have excessive postnasal drop which isn’t related to allergies?  
Yes  No
did you have the sudden appearance of this headache?  
Yes  No
is this headache often very severe, nearly daily being very severe?  
Yes  No
are you much more fatigued since having this new headache?  
Yes  No
does your headache get better in a few minutes of laying down without going to sleep?  
Yes  No
do you have dizziness/lightheadedness/vertigo/imbalance generally since this headache started?  
Yes  No
do you have more of these when the headache is worse?  
Yes  No
did you have any head or spine trauma prior to this new headache?  
Yes  No
do you have a new metallic taste in your mouth?  
Yes  No
do you now have significant neck pain or pain in the back of your head?  
Yes  No
has your hearing worsened since this headache started?  
Yes  No
is your hearing impaired (for example, muffled) when this headache is very severe?  
Yes  No
do you have any new ringing in your ears?  
Yes  No
when the headache is particularly severe, do you have any double vision?  
Yes  No
is there very prominent blurry vision with this headache?  
Yes  No
is there a family history of any of the following diseases:

- Marfan’s syndrome  
  Yes  No
- Ehlers-Danlos syndrome  
  Yes  No
- Polycystic kidney disease  
  Yes  No
- Neurofibromatosis  
  Yes  No

Do you have any facial pain or facial numbness with this headache?  
Yes  No
Are you clumsy with this headache?  
Yes  No
Newly diagnosed stroke?  
Yes  No
Any new slurred speech?  
Yes  No
Any new problems swallowing?  
Yes  No
Any new tremor?  
Yes  No
Any new neck, low back, or spine area pain?  
Yes  No
Any new arm or leg pain?  
Yes  No
After the head pain is gone, do you have any of the following symptoms:

- changes in thirst  
  Yes  No
- changes in appetite  
  Yes  No
- head soreness or tenderness or sensitivity  
  Yes  No
- trouble thinking  
  Yes  No
- fatigue/drowsiness  
  Yes  No
- feeling “hungover”  
  Yes  No
- nausea  
  Yes  No
- vomiting  
  Yes  No
- diarrhea  
  Yes  No
- constipation  
  Yes  No
- weakness  
  Yes  No
- mood changes  
  Yes  No

Have you had any testing done for your headaches? If so, please ensure we got a copy of the films themselves and the report from the radiologist who read the studies. Examples include:

- MRI brain
- MRI cervical spine
- MR angiogram of neck/head
- MR venogram of head
- CT brain
- CT sinuses
- TMJ (temporomandibular joint) x-rays
- Spinal tap/lumbar puncture
- EEG
- Sleep test
- Ultrasound of carotid arteries
- Echocardiogram

Any tests?  Yes  No

Have you ever had any significant head or neck trauma or a concussion?  Yes  No
If so, how many times?  ___________  and when was the last episode?  ___________
Do you have a history of heart problems or stroke/mini-strokes?  Yes  No
Have you ever been diagnosed with “complicated migraine”?  Yes  No
Does anyone in your family have a history of heart problems (heart attack, e.g.) prior to age 60?

Yes ________________________________________________________________  No

Does anyone in your family have a history of stroke or mini-stroke prior to age 60?

Yes ________________________________________________________________  No

Do you or does anyone in your family have a history of seizures or epilepsy (includes petit mal, grand mal, febrile)? Yes ____________________________________  No

Is there any pending legal action related to your headaches? Yes ________________  No

Have you ever had any use or abuse of illicit drugs (including but not limited to marijuana, cocaine, heroin, crystal meth, Ecstasy)? Yes ________________________________  No

Do you or does anyone in your family have a history of problems getting pregnant or a history of multiple miscarriages? Yes ________________________________  No

Do you or does anyone in your family have a history of emotional/psychiatric problems, such as anxiety, depression? Yes ________________________________  No

Do you or does anyone in your family have a history of:

- fibromyalgia syndrome  Yes  No
- chronic widespread pain  Yes  No
- chronic fatigue syndrome  Yes  No
- interstitial cystitis  Yes  No
- IBS (inflammatory/irritable bowel disease)  Yes  No
- multiple chemical sensitivity syndrome  Yes  No
- idiopathic environmental intolerance syndrome? Yes  No

Do you have any neck pain? Yes  No
If you don’t feel rested on awakening in the mornings most of the time, please answer the following questions:

- Do you wake up a lot at night not knowing why? Yes No
- Do you snore, or has someone told you that you snore? Yes No
- Do you have relatives who snore, especially snore loudly? Yes No
- Are you tired during the day most days? Yes No
- If you can nap, do you feel refreshed afterwards? Yes No
- Do you fall asleep quickly when you go to bed? Yes No
- Do you have uncontrollable sleep attacks? Yes No
- Do you ever have spells of losing control over your muscles especially when crying or laughing hard? Yes No
- Do you have vivid dream-like visions on falling asleep or prior to waking up? Yes No
- Have you ever had sleep paralysis? Yes No
- Do you have a problem with losing control of your bowels or bladder when you’re sleeping? Yes No
- Do you sleepwalk, or did you sleepwalk when younger? Yes No
- Do you commonly wake up with a headache? Yes No
- Do you commonly wake up with a sore throat? Yes No
- Do you have pain that keeps you from falling asleep or staying asleep? Yes No
- Do you have leg movements that keep you from falling asleep or staying asleep? Yes No
- Do you have, especially in the evenings, uncomfortable numb, tingly, creeping, or crawling sensations in your legs, which may be made less severe when you move your legs? Yes No
- Do you grind your teeth, especially when sleeping? Yes No
- Have you ever had TMJ? Yes No
- Has any regular bed partner ever complained about your sleep? Yes No

If you drink caffeine daily, about how many servings? _______________

Do you have environmental allergies (“hay fever”), allergic rhinitis? Yes No

Do you take any medications more than twice weekly to treat pain or headache, over-the-counter or prescription ones (including Tylenol, Advil, Motrin)?

Which one(s)? ____________________________________________________

How many times a day? ____________________________________________

How many times in a week? _________________________________________