



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 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!

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BRAIN & SPINE SURGEONS

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



BRAIN & SPINE SURGEONS

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, numbness, tingling, tunnel vision, vertigo, change/loss of smell, things look too large, seeing dots, dizziness, language problems, lightheadedness, hearing issues, things look too small, tongue numbness, seeing zigzag lines, tunnel vision, emotional changes, inspiration or other religious experience, change/loss of taste, touch sensitivity, 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, light and/or sound sensitivity, mood changes, concentration difficulties, diarrhea, feeling need to have a BM, abdominal cramps, cold hands/feet, nasal congestion/drainage, runny eyes, change in pupil size, red eyes, eyelid swelling, droopy eyelid, facial swelling, amnesia, blindness, problems talking, numbness, neck tenderness, nausea with or w/o vomiting, lightheadedness, visual blurring, excess hot or cold feelings, fluid retention, constipation, feeling poorly, loss of appetite, fever/chills, facial flushing, scalp tenderness, lack of coordination, irritability, loss of depth perception, uncontrolled bowels, neck pain/tenderness, confusion, ear ringing, tingling, goose bumps, smell sensitivity, clumsiness, vertigo, tremors, slurred speech, pale, double vision, weakness, excess urination, teeth grinding, fatigue, insomnia, visual loss, passing out, uncontrolled bladder, language problems, shoulder stiffness, hearing loss, "spacey" feeling

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BRAIN & SPINE SURGEONS

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 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 drip 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

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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

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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 |
| If not, how long does it usually take you to fall asleep? _____ hours | |
| 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? _____