Name: ________________________

Date: ________________________

HEADACHE HISTORY

Headache patients are not all the same, so in order to ensure we can provide you as accurate a diagnosis as we can, we would ask your assistance in filling out the following form as completely and as accurately as possible. For nearly all patients this will allow us to begin, on the initial visit, not only the process of getting any further necessary testing completed, but perhaps most importantly, it usually also allows us to begin or change treatment at that first visit.

Further, providing us copies of: (1) all of your prior neurological or headache specialist evaluations; (2) all of your actual radiological studies (on CD) and their corresponding reports; and (3) all of your relevant laboratory studies is required with your initial evaluation. Some patients find it helpful to include copies of their pharmacy records for the prior treatment of their headache, and this is very much appreciated, as well.

Not all questions may pertain to you. The more complete the information you provide on this form, the faster and better we can design your plan of care and thus optimize your time at your initial appointment. This is usually best accomplished by completing it prior to the initial evaluation, not in the waiting room in a hurry prior to being seen. If you have questions, please contact us so we can assist you.

As this is an extensive amount of information, we strongly recommend that you not wait until you arrive at the office to begin the process of filling out this Headache History form. If you prefer to do so, we recommend that you arrive at least an hour prior to your scheduled visit with all of your records to assist in this process. Again, however, we ask that you understand that we may have to reschedule your initial evaluation if these forms are not entirely completed in time for your scheduled initial appointment.

This form is in addition to the basic forms all new patients are asked to complete, as this one is only concerned with the symptom of headache.

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

____
Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

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

Are they 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 often 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?

____

____

Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

Do your headaches seem to occur at certain times of the day? ___________________________

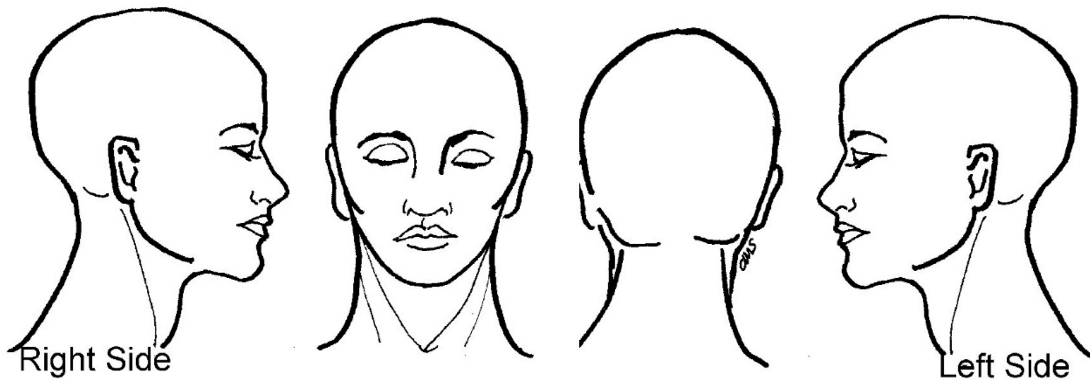
Do headaches wake you up in the middle of the night? Yes No

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, in the below diagram shade the part of the head involved in the pain:



Shade starting area and then complete headache involvement on these diagrams.

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

____
Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

Circle any of the below particular triggers which may seem to provoke your having a headache:

Allergies or sinusitis

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, especially 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 during your teenage years
- menstrual periods (or right before they start)
- time of ovulation (generally two weeks before your period starts)
- use of sex hormones/birth control pills/estrogen/progesterone/testosterone
- pregnancy or after pregnancy
- menopause/premenopause

Changes, such as:

- weather
- barometric pressure
- seasons
- travel, especially across time zones
- altitude
- schedule (e.g., work, sleep, meal times)
- sleeping patterns

oversleeping
undersleeping
skipping meals
fatigue
riding in a car
vacations

____
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Dr. Vaughan

Name: ________________________

Date: ________________________

Sensory stimuli:

- strong lights
- glare
- flickering lights
- strong smells
- head jarring
- hunger
- position
- sexual activity
- sneezing
- straining

stress (or after stress is over)
touching
bending over
chewing
coughing
loud noises
reading in a car
lack of caffeine
eating cold foods/drinks ("ice cream headache")

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 your 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? ______________

____

____

____
Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

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 members or coworkers notice these and tell them so. Circle any of the below symptoms which could predict your having a headache in the next day or so:

mental slowness	light sensitivity	stiff neck
depression	poor concentration	food cravings
hyperactivity	smell sensitivity	cold feelings
fatigue	sound sensitivity	loss/increase of appetite
euphoria (intense happiness)	problems talking	sluggishness
talkativeness	sleep too much	diarrhea
irritability	yawning	constipation
drowsiness	muscle aches	nose bleed
malaise/feeling bad	hot ears	thirst
restlessness		urination
surge of energy		fluid retention

Just before having a headache, within a few hours of the head pain's starting, some headache patients have various symptoms. Circle if you have any of the below symptoms:

visual loss or changes	seeing dots	seeing zigzag lines
numbness	dizziness	tunnel vision
tingling	language problems	emotional changes
tunnel vision	lightheadedness	inspiration/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, how long does that above symptom last? ________________________________

If it stops prior to the head pain, how long is that break in between? ________________________________

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

____
Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

During the actual head pain itself, circle if 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/room spinning
concentration difficulties	excess hot or cold feelings	tremors
diarrhea	fluid retention	slurred speech
feeling need to have a bowel movement	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/poor sleep
eyelid swelling	irritability	visual loss
droopy eyelid	loss of depth perception	passing out
facial swelling	uncontrolled bowels	uncontrolled bladder
amnesia/memory loss	neck pain	language problems
blindness	confusion	shoulder stiffness
problems talking	ear ringing	hearing loss
numbness	tingling	"spacey" feeling
neck tenderness	goose bumps	dizziness

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

your 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?	Yes	No
does it throb with your pulse if you have it?	Yes	No
recent weight gain?	Yes	No

how much? _____________

____

Reviewed by
Dr. Vaughan

Name: ______________________

Date: ______________________

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 symptoms 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

____

Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

Have you had any testing done for your headaches? **<u>If no tests, please circle:</u>** **No**
If yes, **<u>please ensure we got a copy of the films themselves and the report from the radiologist who read the studies</u>**. Examples include (circle if you've had that test):

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

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(s)/mini-stroke(s)? Yes_______________ No

Have you ever been diagnosed with "complicated migraine"? Yes No

Does anyone in your family have a history of heart problems (e.g., heart attack) prior to age 60?

Yes ____ No

Does anyone in your family have a history of stroke(s) or mini-stroke(s) 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 [with a high fever])? Yes ______________________________ No

____
Reviewed by
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Name: ________________________

Date: ________________________

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
chronic fatigue and immune dysfunction syndrome?	Yes	No
unrelenting fatigue?	Yes	No
myalgic encephalomyelitis?	Yes	No

Do you have any neck pain when you don’t have a headache?	Yes	No
Do you have any low back pain when you don’t have a headache?	Yes	No

____
Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

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/temporomandibular joint disorder? 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)? Yes No

Which one(s)? ____

How many times a day? ____

How many days in a week? ____

____

Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

OTHER SYMPTOMS

lightheadedness/ dizziness: Yes No
poor equilibrium/imbalance: Yes No
exercise intolerance: Yes No
extreme fatigue: Yes No
weakness: Yes No
fainting: Yes No
excessive thirst: Yes No
blurry vision/different pupil sizes: Yes No

Any of the above eight symptoms provoked or worsened by:
heat exposure: Yes No
physical exertion: Yes No
heavy meals: Yes No
prolonged bedrest: Yes No
menses/periods: Yes No
drugs (especially blood pressure pills): Yes No

cold extremities (hands and feet): Yes No
disorientation/confusion: Yes No
hypertension (high blood pressure): Yes No
hypotension (low blood pressure): Yes No
variable blood pressure: Yes No
tinnitus (ringing in the ears): Yes No
shortness of breath: Yes No
headache: Yes No
muscle weakness: Yes No
fibromyalgia/chronic fatigue symptoms: Yes No
tremulousness/feeling of an internal tremor: Yes No
visual disturbances: Yes No

brain fog: Yes No
burnout, physical: Yes No
burnout, emotional: Yes No

____
Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

decreased mental stamina: Yes No
depression: Yes No
difficulty finding the right word: Yes No
impaired concentration: Yes No
sleep disorders: Yes No
anxiety: Yes No and how severe (mild, moderate, severe): ______

heart rhythm problems: Yes No
palpitations (feeling of an irregular heartbeat): Yes No
heart attack: Yes No
chest pain/discomfort: Yes No

feelings of chills: Yes No
feelings of fear: Yes No
flushing/getting red in the face: Yes No
getting pale in the face: Yes No
overheating: Yes No
nervousness: Yes No
overstimulation: Yes No
noise sensitivity: Yes No
light sensitivity: Yes No

abdominal pain or discomfort: Yes No
bloating/excessive feeling of full stomach: Yes No
constipation: Yes No
diarrhea: Yes No
nausea: Yes No
vomiting: Yes No
excessive urination/other bladder problems: Yes No
loss of hunger sensation: Yes No
loss of sex drive: Yes No

A prior diagnosis of a small-fiber peripheral neuropathy ("small-fiber neuropathy"): Yes No

____
Reviewed by
Dr. Vaughan

Name: ______________________

Date: ______________________

Any sensory symptoms (numbness, tingling, or pain): Yes No

restless legs syndrome diagnosis or symptoms: Yes No
dry mouth/eYes? Yes No
feet pale or blue? Yes No
feet colder than rest of body? Yes No
sweating in feet less than in rest of body? Yes No
sweating in feet decreased or absent, e.g., after exercise or during hot weather? Yes No
sweating in hands increased over rest of body? Yes No
nausea, vomiting, or bloating after eating a small meal? Yes No
persistent diarrhea (> 3 loose BM's daily)? Yes No
persistent constipation (< 1 BM qod)? Yes No
urinary leaking? Yes No

Prior diagnosis of:
"chronic fatigue syndrome (CFS)" Yes No
"fibromyalgia syndrome (FMS)" Yes No
"interstitial cystitis (IC)" Yes No
"irritable bowel syndrome (IBS)" Yes No
"multiple chemical sensitivity syndrome (MCS)" Yes No
"idiopathic environmental intolerance syndrome (IEI)" Yes No
"chronic fatigue and immune dysfunction syndrome (CFIDS)" Yes No
"unrelenting fatigue (UF)" Yes No
"myalgic encephalomyelitis (ME)" Yes No
"chronic widespread pain (CWP)" Yes No

Diagnosis of rheumatological/arthritis disease: Yes No
Diagnosis of Ehlers-Danlos syndrome/other joint hypermobility disorder: Yes No
Known viral illness before these symptoms started: Yes No
Closed head injury (CHI)/traumatic brain injury (TBI) history? Yes No

Date of last event of head trauma: ____________________________
Total number of concussions: ____________________________

____
Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

Below symptoms as part of CHI/TBI diagnosis?

Headache (new or change in prior headache): Yes No
Nausea/vomiting: Yes No
Drowsiness: Yes No
Dizziness: Yes No
Fatigue: Yes No
Irritability: Yes No
Sensitivity to Noise: Yes No
Sensitivity to light: Yes No
Visual changes (blurry or double vision): Yes No
Tinnitus/ringing in ears: Yes No
Hearing loss: Yes No
Decrease in smell and/or taste: Yes No
Sleep problems especially problems falling asleep: Yes No
Poor concentration: Yes No
Memory problems: Yes No
Unable to tolerate stress: Yes No
Unable to tolerate alcohol intake: Yes No
Changes in how you look (look sad, depressed): Yes No
Increased/new anxiety: Yes No
Increased/new depression: Yes No
Personality changes: Yes No
Apathy/loss of interest in daily life: Yes No
Poor judgment: Yes No
Restlessness: Yes No
Aggression: Yes No
Mood swings: Yes No
Anger: Yes No
Decreased or lost sex drive: Yes No

Family history of similar symptoms to yours? Yes No

____
Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

How often do you experience increased pain or an unpleasant sensation on your skin during your most severe type of headache when you engage each of the following?	Does not apply to me	Never	Rarely	Less than half the time	Half the time or more
	Score: 0	**Score: 0**	**Score: 0**	**Score: 1**	**Score: 2**
Combing your hair					
Pulling your hair back (e.g., ponytail)					
Shaving your face					
Wearing eyeglasses					
Wearing contac lenses					
Wearing earrings					
Wearing a necklace					
Wearing tight clothing					
Taking a shower (when shower water hits your face)					
Resting your face or head on a pillow					
Exposure to heat (e.g., cooking, washing your face with hot water)					
Exposure to cold (e.g., using an icepack, washing your face with cold water					
Total score of each column					
Sum of total scores					

Name: ________________________

Date: ________________________

Instructions to patient: "Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then fill in the circle of the response to indicate how much you have been bothered by that problem **IN THE PAST MONTH**." Please fill in ONE option only for each question."

	Response	Not at all (1)	A little bit (2)	Moderate (3)	Quite a bit (4)	Extreme (5)
1.	Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because *they remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

____
Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

How often over the last 2 weeks have the below bothered you?	Not at all	Several days	➢ Half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

____

Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score: = Add Columns ________ + ________+ ________

= ____________ **(total score)**

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all ____________

Somewhat difficult ____________

Very difficult ____________

Extremely Difficult ____________

____
Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your healthcare professional.

1. On how many days in the last 3 months did you miss work or school because of your headaches?

   ____

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

   ____

3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

   ____

4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

   ____

5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

   ____

Total (add all of the answers to questions 1-5) : ____________

What your Physician will need to know about your headache:

1. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.)

   ____

2. On a scale of 0 - 10, on average how painful were these headaches? (where 0=no pain at all, and 10= pain as bad as it can be.)

   ____

____
Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

Use the following scale to choose the most appropriate number for each situation:
0 = would *never* doze or sleep during that activity
1 = *slight* chance of dozing or sleeping during that activity
2 = *moderate* chance of dozing or sleeping during that activity
3 = *high* chance of dozing or sleeping during that activity

SITUATION	CHANCE OF SLEEPING
Sitting and reading	____
Watching TV	____
Sitting inactive in a public place	____
Being a passenger in a motor vehicle for an hour or more	____
Lying down in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in traffic while driving	____
Total score (add the scores up)	____

____
Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE

____

____
Reviewed by
Dr. Vaughan

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Date: ________________________

I have pain all over my body.	Yes	No
My pain is accompanied by a continuous and very unpleasant general fatigue.	Yes	No
My pain feels like burns, electric shocks, or cramps.	Yes	No
My pain is accompanied by other unusual sensations throughout my body, such as pins and needles, tingling, or numbness.	Yes	No
My pain is accompanied by other health problems such as digestive problems, urinary problems, headaches, or restless legs.	Yes	No
My pain has a significant impact on my life, particularly on my sleep and my ability to concentrate, making me feel slower generally.	Yes	No

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When you have headaches, how often is the pain severe?

Never Rarely Sometimes Very Often Always

How often do headaches limit your ability to do usual daily activities, including household work, work, school, or social activities?

Never Rarely Sometimes Very Often Always

When you have a headache, how often do you wish you could lie down?

Never Rarely Sometimes Very Often Always

In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

Never Rarely Sometimes Very Often Always

In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

Never Rarely Sometimes Very Often Always

In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

Never Rarely Sometimes Very Often Always
0

Column _____ _____ _____ _____ _____
Totals

____
Reviewed by
Dr. Vaughan

Name: ________________________

Date: ________________________

MEDICATION	CURRENTLY TAKING?	EVER TAKEN?	WHEN/HOW	FREQUENCY	MAXIMUM	HELPFUL?	RATE HELPFULNESS:	ANY SIDE EFFECTS?
			LONG TAKEN	OF DOSING	DOSE		1=MILD;2-MOD;3=MUCH	
ANTIDEPRESSANTS/PSYCHOACTIVE MEDICATIONS								
Elavil (amitriptyline)	Yes No	Yes No				Yes No		
Pamelor (nortriptyline)	Yes No	Yes No				Yes No		
Vivactil (protriptyline)	Yes No	Yes No				Yes No		
Tofranil (imipramine)	Yes No	Yes No				Yes No		
Norpramin (desipramine)	Yes No	Yes No				Yes No		
Sinequan (doxepin)	Yes No	Yes No				Yes No		
Asendin (amoxapine)	Yes No	Yes No				Yes No		
Anafranil (clomipramine)	Yes No	Yes No				Yes No		
Desyrel (trazodone)	Yes No	Yes No				Yes No		
Nardil (phenelzine)	Yes No	Yes No				Yes No		
Parnate (tranylcypromine)	Yes No	Yes No				Yes No		
Eskalith (lithium)	Yes No	Yes No				Yes No		
Prozac (fluoxetine)	Yes No	Yes No				Yes No		
Zoloft (sertraline)	Yes No	Yes No				Yes No		
Paxil (paroxetine)	Yes No	Yes No				Yes No		
Celexa (citalopram)	Yes No	Yes No				Yes No		
Lexapro (escitalopram)	Yes No	Yes No				Yes No		

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Reviewed by
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Effexor (venlafaxine)	Yes No	Yes No				Yes No		
Pristiq (desvenlafaxine)	Yes No	Yes No				Yes No		
Cymbalta (duloxetine)	Yes No	Yes No				Yes No		
Remeron (mirtazapine)	Yes No	Yes No				Yes No		
Luvox (fluvoxamine)	Yes No	Yes No				Yes No		
Buspar (buspirone)	Yes No	Yes No				Yes No		
Savella (milnacipran)	Yes No	Yes No				Yes No		
Serzone (nefazodone)	Yes No	Yes No				Yes No		
Viibryd (vilazodone)	Yes No	Yes No				Yes No		
Wellbutrin (bupropion)	Yes No	Yes No				Yes No		
Silenor (doxepin)	Yes No	Yes No				Yes No		
Zelapor (selegilene)	Yes No	Yes No				Yes No		
Abilify (aripiprazone)	Yes No	Yes No				Yes No		
Zyprexa (olanzapine)	Yes No	Yes No				Yes No		
Seroquel (quetiapine)	Yes No	Yes No				Yes No		
Risperdal (risperidone)	Yes No	Yes No				Yes No		
Geodon (ziprasodone)	Yes No	Yes No				Yes No		
Thorazine (chlorpromazine)	Yes No	Yes No				Yes No		
Inapsine (droperidol)	Yes No	Yes No				Yes No		
Haldol (haloperidol)	Yes No	Yes No				Yes No		

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Mellaril (thioridazine)	Yes No	Yes No				Yes No		
Navane (thiothixene)	Yes No	Yes No				Yes No		
ANTICONVULSANTS/ANTISEIZURE MEDICATIONS	Yes No	Yes No				Yes No		
Depakote (valproic acid/sodium valproate)	Yes No	Yes No				Yes No		
Neurontin (gabapentin)	Yes No	Yes No				Yes No		
Lyrica (pregabalin)	Yes No	Yes No				Yes No		
phenobarbital	Yes No	Yes No				Yes No		
Mysoline (primidone)	Yes No	Yes No				Yes No		
Dilantin (phenytoin)	Yes No	Yes No				Yes No		
Tegretol (carbamazepine)	Yes No	Yes No				Yes No		
Trileptal (oxcarbazepine)	Yes No	Yes No				Yes No		
Oxtellar (extended-release oxcarbazepine)	Yes No	Yes No				Yes No		
Aptiom (eslicarbazepine)	Yes No	Yes No				Yes No		
Topamax (topiramate)	Yes No	Yes No				Yes No		
Trokendi (extended-release topiramate)	Yes No	Yes No				Yes No		
Lamictal (lamotrigine)	Yes No	Yes No				Yes No		
Zonegran (zonisamide)	Yes No	Yes No				Yes No		
Gabitril (tiagabine)	Yes No	Yes No				Yes No		

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Keppra (levetiracetam)	Yes No	Yes No				Yes No		
Briviact (brevitiracetam)	Yes No	Yes No				Yes No		
Potiga (ezogabine)	Yes No	Yes No				Yes No		
Banzel (rufinamide)	Yes No	Yes No				Yes No		
Fycompa (perampanel)	Yes No	Yes No				Yes No		
Gralise (extended-release Neurontin/gabapentin)	Yes No	Yes No				Yes No		
Horizant (gabapentin enacarbil)	Yes No	Yes No				Yes No		
<u>ANTIHYPERTENSIVES/BLOOD PRESSURE MEDICATIONS</u>	Yes No	Yes No				Yes No		
Inderal (propranolol)	Yes No	Yes No				Yes No		
Corgard (nadolol)	Yes No	Yes No				Yes No		
Blocadren (timolol)	Yes No	Yes No				Yes No		
Toprol/Lopressor (metoprolol)	Yes No	Yes No				Yes No		
Tenormin (atenolol)	Yes No	Yes No				Yes No		
Calan/Verelan/Isoptin (verapamil)	Yes No	Yes No				Yes No		
Norvasc (amlodipine)	Yes No	Yes No				Yes No		
Procardia (nifedipine)	Yes No	Yes No				Yes No		
Cardizem (diltiazem)	Yes No	Yes No				Yes No		
Catapres (clonidine)	Yes No	Yes No				Yes No		

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Benicar (olmesartan)	Yes No	Yes No				Yes No		
Atacand (candesartan)	Yes No	Yes No				Yes No		
Cozaar (losartan)	Yes No	Yes No				Yes No		
Plendil (felodipine)	Yes No	Yes No				Yes No		
Cardene (nicardipine)	Yes No	Yes No				Yes No		
Capoten (captopril)	Yes No	Yes No				Yes No		
Vasotec (enalapril)	Yes No	Yes No				Yes No		
Lotensin (benazepril)	Yes No	Yes No				Yes No		
Prinivil/Zestril (lisinopril)	Yes No	Yes No				Yes No		
HORMONES	Yes No	Yes No				Yes No		
oral contraceptives (birth control pills)	Yes No	Yes No				Yes No		
estrogen	Yes No	Yes No				Yes No		
progesterone	Yes No	Yes No				Yes No		
Testosterone	Yes No	Yes No				Yes No		
SKELETAL MUSCLE RELAXANTS	Yes No	Yes No				Yes No		
Soma (carisoprodol)	Yes No	Yes No				Yes No		
Flexeril (cyclobenzaprine)	Yes No	Yes No				Yes No		

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Amrix (cyclobenzaprine)	Yes No	Yes No				Yes No		
Robaxin (methocarbamol)	Yes No	Yes No				Yes No		
Zanaflex (tizanidine)	Yes No	Yes No				Yes No		
Lioresal (baclofen)	Yes No	Yes No				Yes No		
Norflex/Norgesic (orphenadrine)	Yes No	Yes No				Yes No		
Skelaxin (metaxalone)	Yes No	Yes No				Yes No		
Parafon Forte (chlorzoxazine)	Yes No	Yes No				Yes No		
Lorzone (chlorzoxazine)								
ANXIOLYTICS/ANTI-ANXIETY MEDICATIONS	Yes No	Yes No				Yes No		
Valium (diazepam)	Yes No	Yes No				Yes No		
Ativan (lorazepam)	Yes No	Yes No				Yes No		
Xanax (alprazolam)	Yes No	Yes No				Yes No		
Klonopin (clonazepam)	Yes No	Yes No				Yes No		
Librium (chlordiazepoxide)	Yes No	Yes No				Yes No		
Tranxene (clorazepate)	Yes No	Yes No				Yes No		
Restoril (temazepam)	Yes No	Yes No				Yes No		

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SLEEP/ADD/ADHD MEDICATIONS	Yes No	Yes No				Yes No		
Provigil (modafinil)	Yes No	Yes No				Yes No		
Nuvigil (armodafanil)	Yes No	Yes No				Yes No		
Somnote (chloral hydrate)	Yes No	Yes No				Yes No		
Adderall (dextroamphetamine)	Yes No	Yes No				Yes No		
melatonin	Yes No	Yes No				Yes No		
Cylert (pemoline)	Yes No	Yes No				Yes No		
Rozerem (ramelteon)	Yes No	Yes No				Yes No		
Sonata (zaleplon)	Yes No	Yes No				Yes No		
Lunesta (eszopiclone)	Yes No	Yes No				Yes No		
Ambien (zolpidem)	Yes No	Yes No				Yes No		
Vyvanse (lisdexamfetamine)	Yes No	Yes No				Yes No		
Ritalin (methylphenidate)	Yes No	Yes No				Yes No		
Concerta (methylphenidate)	Yes No	Yes No				Yes No		
ALLERGY DRUGS (ANTIHISTAMINES/DECONGESTANTS/OTHER	Yes No	Yes No	-	-	-	Yes No	-	-
Zyrtec (cetirizine)	Yes No	Yes No				Yes No		
Claritin (loratadine)	Yes No	Yes No				Yes No		
Allegra (fexofenadine)	Yes No	Yes No				Yes No		
Sudafed (pseudoephedrine)	Yes No	Yes No				Yes No		

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Benadryl (diphenhydramine)	Yes No	Yes No				Yes No		
Chlortrimeton (chlorpheniramine)	Yes No	Yes No				Yes No		
Periactin (cyproheptadine)	Yes No	Yes No				Yes No		
Dramamine (dimenhydrinate)	Yes No	Yes No				Yes No		
hydroxyzine (Vistaril; Atarax)	Yes No	Yes No				Yes No		
Antivert (meclizine)	Yes No	Yes No				Yes No		
Singulair (montelukast)	Yes No	Yes No				Yes No		
SUPPLEMENTS/HERBS/OTHER MEDICATIONS	Yes No	Yes No				Yes No		
Petadolex (butterbur)	Yes No	Yes No				Yes No		
feverfew	Yes No	Yes No				Yes No		
riboflavin/vitamin B2	Yes No	Yes No				Yes No		
magnesium	Yes No	Yes No				Yes No		
coenzyme Q10	Yes No	Yes No				Yes No		
fish oil	Yes No	Yes No				Yes No		
Vayacog/other omega-3 fatty acids	Yes No	Yes No				Yes No		
5-hydroxytriptophan/oxitriptan	Yes No	Yes No				Yes No		
St. John's Wort	Yes No	Yes No				Yes No		
ginger	Yes No	Yes No				Yes No		

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Migrelief (feverfew/magnesium/riboflavin)	Yes No	Yes No				Yes No		
oxygen	Yes No	Yes No				Yes No		
marijuana	Yes No	Yes No				Yes No		
Marinol (dronabinol)	Yes No	Yes No				Yes No		
Azilect (rasagaline)	Yes No	Yes No				Yes No		
Methergine (methylergonovine)	Yes No	Yes No				Yes No		
Sansert (methysergide)	Yes No	Yes No				Yes No		
Namenda (memantine)	Yes No	Yes No				Yes No		
lidoderm patch	Yes No	Yes No				Yes No		
pain creams/gels (please list ingredients)	Yes No	Yes No				Yes No		
ACTIVITIES	Yes No	Yes No				Yes No		
acupuncture	Yes No	Yes No				Yes No		
chiropractic treatment/manipulation	Yes No	Yes No				Yes No		
dry needling	Yes No	Yes No				Yes No		
physical therapy	Yes No	Yes No				Yes No		
biofeedback	Yes No	Yes No				Yes No		
aromatherapy	Yes No	Yes No				Yes No		
essential oils	Yes No	Yes No				Yes No		
relaxation therapy	Yes No	Yes No				Yes No		

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cognitive therapy	Yes No	Yes No				Yes No		
psychotherapy	Yes No	Yes No				Yes No		
reflexology	Yes No	Yes No				Yes No		
massage therapy	Yes No	Yes No				Yes No		
dietary changes	Yes No	Yes No				Yes No		
avoidance of triggering activities	Yes No	Yes No				Yes No		
PROCEDURES	Yes No	Yes No				Yes No		
Botox	Yes No	Yes No				Yes No		
trigger point injections	Yes No	Yes No				Yes No		
nerve blocks	Yes No	Yes No				Yes No		
sphenopalatine ganglion blocks (SPG blocks)	Yes No	Yes No				Yes No		
DEVICES								
TENS unit	Yes No	Yes No				Yes No		
Cefaly	Yes No	Yes No				Yes No		

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Cerena	Yes No	Yes No				Yes No		
TRIPTANS	Yes No	Yes No				Yes No		
Imitrex injectable (sumatriptan)	Yes No	Yes No				Yes No		
Sumavel (needleless sumatriptan)	Yes No	Yes No				Yes No		
Alsuma (sumatriptan injectable with a needle)	Yes No	Yes No				Yes No		
Zecuity (sumatriptan patch)	Yes No	Yes No				Yes No		
Onzetra Xsail (sumatriptan powder)	Yes No	Yes No				Yes No		
Imitrex nasal spray (sumatriptan)	Yes No	Yes No				Yes No		
Treximet (sumatriptan + naprosyn)	Yes No	Yes No				Yes No		
Imitrex pills (25, 50, 100 mg) (sumatriptan)	Yes No	Yes No				Yes No		
Maxalt MLT (5, 10 mg) (rizatriptan)	Yes No	Yes No				Yes No		
Maxalt tabs (5, 10 mg) (rizatriptan)	Yes No	Yes No				Yes No		
Zomig tabs (2.5, 5 mg) (zolmitriptan)	Yes No	Yes No				Yes No		
Zomig ZMT (2.5, 5 mg) (zolmitriptan)	Yes No	Yes No				Yes No		
Zomig nasal spray (zolmitriptan)	Yes No	Yes No				Yes No		
Relpax (eletriptan)	Yes No	Yes No				Yes No		
Axert (almotriptan)	Yes No	Yes No				Yes No		
Amerge (naratriptan)	Yes No	Yes No				Yes No		
Frova (frovatriptan)	Yes No	Yes No				Yes No		

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ERGOTS	Yes No	Yes No				Yes No		
Cafergot pills (ergotamine)	Yes No	Yes No				Yes No		
Cafergot suppositories (ergotamine)	Yes No	Yes No				Yes No		
Migranal (DHE) nasal spray	Yes No	Yes No				Yes No		
DHE injectable	Yes No	Yes No				Yes No		
Levadex (DHE inhaler)	Yes No	Yes No				Yes No		
Bellergal (belladonna - ergotamine - phenobarbital)	Yes No	Yes No				Yes No		
NSAIDsCOX-II inhibitors	Yes No	Yes No				Yes No		
ibuprofen (Motrin, Advil)	Yes No	Yes No				Yes No		
naproxen (Naprosyn, Aleve)	Yes No	Yes No				Yes No		
diclofenac (Voltaren, Cataflam, Cambia, Zipsor)	Yes No	Yes No				Yes No		
Orudis (ketoprofen)	Yes No	Yes No				Yes No		
Clinoril (sulindac)	Yes No	Yes No				Yes No		
Indocin (indomethacin)	Yes No	Yes No				Yes No		
Relafen (nabumetone)	Yes No	Yes No				Yes No		
Feldene (piroxicam)	Yes No	Yes No				Yes No		
Nalfon (fenoprofen)	Yes No	Yes No				Yes No		

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Dolobid (diflunisal)	Yes No	Yes No				Yes No		
Ansaid (flurbiprofen)	Yes No	Yes No				Yes No		
Daypro (oxaprozin)	Yes No	Yes No				Yes No		
Lodine (etodolac)	Yes No	Yes No				Yes No		
Arthrotec (diclofenac/misoprostol)	Yes No	Yes No				Yes No		
Toradol (ketorolac): shots, pills, nasal spray (Sprix)	Yes No	Yes No				Yes No		
Vioxx (rofecoxib)	Yes No	Yes No				Yes No		
Celebrex (celecoxib)	Yes No	Yes No				Yes No		
Bextra (valdecoxib)	Yes No	Yes No				Yes No		
Mobic (meloxicam)	Yes No	Yes No				Yes No		
SALICYLATES (ASPIRIN)/TYLENOL/COMBINATIONS	Yes No	Yes No				Yes No		
aspirin	Yes No	Yes No				Yes No		
Tylenol (acetaminophen)	Yes No	Yes No				Yes No		
Midrin/Epidrin (isometheptene/dichloralphenazone/Tylenol)	Yes No	Yes No				Yes No		
Tylenol/aspirin/caffeine (Excedrin; Anacin; Midol; Goody	Yes No	Yes No				Yes No		
Powders; Vanquish; BC powders)	Yes No	Yes No				Yes No		

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ANTIEMETICS/ANTI NAUSEA/VOMITING	Yes No	Yes No				Yes No		
Tigan (trimethobenzamide) tabs/suppositories	Yes No	Yes No				Yes No		
Reglan (metoclopramide)	Yes No	Yes No				Yes No		
Phenergan (promethazine) tabs/suppositories	Yes No	Yes No				Yes No		
Compazine (prochlorperazine) tabs/suppositories	Yes No	Yes No				Yes No		
Zofran (tabs; ODT)	Yes No	Yes No				Yes No		
BUTALBITAL COMBINATIONS	Yes No	Yes No	-	-	-	Yes No	-	-
Fioricet (with Tylenol and caffeine); can have codeine	Yes No	Yes No				Yes No		
Fiorinal (with aspirin and caffeine); can have codeine	Yes No	Yes No				Yes No		
Phrenilin (butalbital/Tylenol)	Yes No	Yes No				Yes No		
STEROIDS (prednisone; methylprednisolone)	Yes No	Yes No				Yes No		
lidocaine nasal spray/drops	Yes No	Yes No				Yes No		

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NARCOTICS	Yes No	Yes No				Yes No		
Fentora (fentanyl oral dissolving tablets)	Yes No	Yes No				Yes No		
Duragesic (fentanyl patch)	Yes No	Yes No				Yes No		
hydrocodone (Lortab; Vicodin; Lorcet; Norco; Vicoprofen; Zydone)	Yes No	Yes No				Yes No		
Tylenol #3 or Tylenol # 4 (codeine)	Yes No	Yes No				Yes No		
Darvon (propoxyphene); Darvocet (propoxyphene + Tylenol)	Yes No	Yes No				Yes No		
oxycodone (Oxycontin; Oxy IR; Percocet)	Yes No	Yes No				Yes No		
Demerol (meperidine)	Yes No	Yes No				Yes No		
Stadol nasal spray (butorphanol)	Yes No	Yes No				Yes No		
Nubain (nalbuphine)	Yes No	Yes No				Yes No		
Actiq (fentanyl dissolving)	Yes No	Yes No				Yes No		
Talwin (pentazocine)	Yes No	Yes No				Yes No		
Dilaudid (hydromorphone)	Yes No	Yes No				Yes No		
Butrans (buprenorphine)	Yes No	Yes No				Yes No		
Nucynta (tapentadol)	Yes No	Yes No				Yes No		
Opana (oxymorphone)	Yes No	Yes No				Yes No		
Dolophine (methadone)	Yes No	Yes No				Yes No		
Ultram (tramadol)	Yes No	Yes No				Yes No		
Ultracet (tramadol + Tylenol)	Yes No	Yes No				Yes No		

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