Dear Patient,

In order to fully evaluate your headache condition, I would like you to fill out this headache survey before we meet in the office. Please bring it with you to your appointment.

1. When did the headaches begin? (age of onset) ________________________________________________________

2. If you have had headaches for years, what were they like in the beginning (frequency, location, severity, etc.)?

   Were they associated with nausea, light and/or sound sensitivity? ❑ Yes ❑ No
   Were they so bad that they caused you to go home from school or work? ❑ Yes ❑ No

3. In the past year, on average, how many total days per month do you have ANY headache? ________/30 days

   On average how many days per month do you have a SEVERE headache? ________/30 days

   On average, how many days per month do you take something to treat the headache pain? ________/30 days

4. If you have daily or near daily headaches, how long have they been noted on a daily or near daily basis?

   ________________________________________________________

5. Have your headaches changed significantly in frequency or severity in the recent past? ❑ Yes ❑ No

6. Where are the headaches located? (Check all that apply)
   ❑ Neck  ❑ Behind the eye  ❑ Back of the head  ❑ Temples  ❑ Forehead  ❑ Top of the head
   Are your headaches generally  ❑ On one side?  ❑ On both sides?
   If one-sided, are they always on the same side? ________________________________________________________

7. Please describe the pain. (Check all that apply).
   ❑ Throbbing  ❑ Pounding  ❑ Vice-Like  ❑ Tightening  ❑ Other _____________________________________________

8. If untreated, how long do they last? ❑ Minutes  ❑ Hours  ❑ Days

   On average, how long does it take for your headaches to reach their peak intensity?
   ❑ Minutes  ❑ Hours  ❑ Other ________________________________________________________________

9. Please rate the range of severity of your headaches where 0 is no pain and 10 is the worst pain that you have ever experienced. Average headache severity ___________Worst headache severity _______________

10. What percentage of the time do you headache wake you up from sleep?
    ❑ 0%  ❑ 25%  ❑ 50%  ❑ >50%

11. Does stress make your headaches worse? ❑ Yes ❑ No ❑ Unsure

    Do you tend to have more (or less) headaches on weekends/vacations (i.e., less stressful times)? ____________

CONTINUED ON OTHER SIDE
12. Do you feel any different one to two days before your headache occurs (e.g., euphoria, irritable, hyperactive, depressed, agitated, anxious)?

Do you crave certain foods, note excessive yawning or have significant neck pain before the headache comes on?

---

13. Do you have warning signs that the headache is soon to occur (an aura)?

Do you experience: (Check all that apply)

- visual zigzag lines
- blackened portions of visual field
- one-sided visual loss
- disturbance in sense of smell
- distorted visual shapes
- one-sided numbness, tingling
- flashing or shimmering lights in your visual field
- difficulty with speech

How soon do the headaches come on after the aura is finished?

---

14. During the headaches, are there any associated symptoms? (Check all that apply)

- room spinning
- nausea
- numbness/tingling
- sensitivity to bright lights
- sensitivity to sounds and/or odors
- vomiting
- difficulty with speech
- other

---

15. Sleep Habits: Are you a good sleeper? ☐ Yes ☐ No  If no, do you have: ☐ problems falling asleep, ☐ staying asleep ☐ both?

How many nights of good, restful sleep do you get per week?

---

16. Does anything in particular bring on the headache? (Check all that apply)

- exercise
- certain odors
- caffeine
- strobe/flickering lights
- fatigue
- prolonged hunger
- sexual relations/orgasm
- sneezing
- glare/bright lights
- high humidity
- fast action movies/video games
- certain types of alcohol
- certain foods
- menstrual periods
- stress
- weather changes
- lack of sleep
- change of seasons
- other

---

17. Habits: Do you smoke cigarettes? __________ If so, how much and for how many years? __________

How much alcohol do you drink in a week’s time? __________

How many cups of caffeinated coffee, tea or cola do you drink each day? __________

---

18. What is your occupation? __________

Have you ever had to take off work/school or alter your activities of daily living because of headaches? __________

How many days of work/school per month on average do you miss because of headaches? __________

How many days of work/school per month do you report with a headache but are significantly less effective than usual? __________

---

19. Other Conditions: Have you ever been diagnosed with: (Check all that apply)

- manic depressive (bipolar) disorder
- Raynaud’s phenomenon
- post traumatic stress disorder
- anxiety/panic attacks
- physical/sexual abuse
- vertigo/dizziness
- depression
- obstructive sleep apnea
- seizures

Are you currently being treated for any of these conditions? __________
20. Do “sick” headaches or migraines run in your family (mom, sister, etc.)? 

21. WOMEN: At what age did you first begin menstruating? 

Are your headaches related to your periods or ovulation?  

If so, when do they occur in relation to your period (before, during, or after)? 

Have you ever been pregnant? 

If yes, did your headaches change during pregnancy? 

Do you take birth control pills or other female hormones? 

22. Do you take pain medications (prescription or non-prescription) more than 2 days/week? 

What do you take to treat the pain? 

List all the over-the-counter pills you have taken in the past four weeks (pain pills, herbs, vitamins, etc.): 

23. Childhood Migraine Equivalents: Did you have significant motion (car) sickness in childhood? 

Did you have intermittent episodes of significant nausea/vomiting and/or abdominal pain in childhood? 

24. Trauma/Injuries: Have you ever been knocked out or suffered a significant serious head injury? 

Have you ever had a significant motor vehicle (car) accident? 

25. Have you ever been treated for your headaches before by someone other than your primary care provider? 

26. What tests have been done to evaluate your headaches?
## Previous Medications and Treatments

Please use the following abbreviations:

<table>
<thead>
<tr>
<th>E</th>
<th>NE</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>medication/treatment taken and effective</td>
<td>medication/treatment taken and not effective</td>
<td>medication treatment taken and not tolerated</td>
</tr>
</tbody>
</table>

### Preventive – Medications taken every day

(If more than one medication is listed, please circle whichever med was taken)

- Inderal (propranolol)/Corgard (nadolol)/Tenormin (atenolol)/Toprol (Metoprolol)
- Elavil (amitryptyline)/Pamelor (nortriptyline)/Tofranil (imipramine)
- Calan/Isoptin/Verelan (verapamil)
- Depakote (valproic acid)

Please use the following abbreviations:

<table>
<thead>
<tr>
<th>E</th>
<th>NE</th>
</tr>
</thead>
<tbody>
<tr>
<td>medication/treatment taken and effective</td>
<td>medication/treatment taken and not effective</td>
</tr>
</tbody>
</table>

### Abortive – Medications taken to treat the acute headache

(If more than one medication is listed, please circle whichever med was taken)

- Aspirin
- Tylenol (acetaminophen)
- Excedrin/Anacin/Vanquish
- Ibuprofen/Advil/Naproxen/Aleve
- Fiorinal/Fioricet/Esgic
- Cafergot/Ergostat/Wigraine
- Midrin (isometheptene/dichloralphenazone/APAP)
- Demerol/Tylenol with codeine/
  Vicodin (hydrocodone)/Percocet (oxycodone)

Please use the following abbreviations:

<table>
<thead>
<tr>
<th>E</th>
<th>NE</th>
</tr>
</thead>
<tbody>
<tr>
<td>medication/treatment taken and effective</td>
<td>medication/treatment taken and not effective</td>
</tr>
</tbody>
</table>

### Other

- Acupuncture/Acupressure
- Chiropractic
- Physical therapy/Massage therapy
- Stress reduction/Yoga/Meditation/Biofeedback

- Cranial sacral therapy
- Nerve blocks
- Ice/cold compresses
- Other

### What are your goals for treatment?

__________________________________________________________________________________________________

### Do you have any other questions regarding headaches?

__________________________________________________________________________________________________

Please use the following abbreviations:

<table>
<thead>
<tr>
<th>E</th>
<th>NE</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>medication/treatment taken and effective</td>
<td>medication/treatment taken and not effective</td>
<td>medication treatment taken and not tolerated</td>
</tr>
</tbody>
</table>
Dear Patient:
Welcome to Dean Clinic – East. Please take a moment to fill out this medical history form so that your physician can get better acquainted with your medical history. We realize that not all of the questions may pertain to you, but please answer all questions that apply. Thank you.

If you are new to this clinic, who was your previous primary care physician? ____________________________________

PAST MEDICAL HISTORY:
1. Please list any active medical problems for which you are currently being treated, such as hypertension, diabetes, high cholesterol, asthma, seizures.
________________________________________________________________________________________________________
________________________________________________________________________________________________________

2. Please list your surgeries with the date(s)
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

3. Please list your non-surgical hospitalizations with the date(s)
________________________________________________________________________________________________________
________________________________________________________________________________________________________

4. Please list any major accidents or injuries with the date(s)
________________________________________________________________________________________________________

PREVENTIVE INFORMATION
Have you ever had (and date):
Flu Vaccine _______________________________________________ Hepatitis-B Vaccine ____________________________
Pneumonia Vaccine _______________________________________ Tetanus Vaccine _______________________________

Do you use seat belts? □ Always □ Sometimes □ Never

Do you have smoke detectors in your home/apartment? □ Yes □ No

Do you have a loaded firearm in your home/apartment? □ Yes □ No
If yes, how is it stored? ________________________________
(Note: this question is only intended to raise awareness about safe storage of firearms)

WOMEN: When was your last:
Pap smear___________________________________  Mammogram _______________________________________________
Bone density study __________________________  Do you perform self breast exams regularly? □ Yes □ No

SOCIAL HISTORY / LIFESTYLE:
Where were you born and raised? _________________ How long have you been in this area? _______________

Do you still drive an automobile? □ Yes □ No
Marital status? (Please check) □ Single □ Married □ Widowed □ Divorced □ Separated

Who lives at home with you? ________________________________

Occupation? ________________________________ Your hobbies? ________________________________

– Please continue on reverse side –
SOCIAL HISTORY / LIFESTYLE (continued):

- Do you ride a motorcycle / bicycle? □ Yes □ No
  - If yes, do you wear a helmet? □ Always □ Sometimes □ Never

- Do you smoke or use nicotine products? □ Yes □ No
  - How many years? _______________________
    - Cigarettes (# Packs / day) _______________________
    - Cigars □ Pipe □ Chew tobacco

- Have you ever used recreational drugs? □ Yes □ No
  - If yes, when was the last time? _______________
    - What kind did you use? ____________________________

- Do you take over-the-counter medication (such as aspirin, antacids, vitamins, herbal products, cold preparations) more than once a week? □ Yes □ No
  - If yes, which ones and how often? __________________

- Do you take calcium supplements? □ Yes □ No
  - How many servings of milk, cheese, cottage cheese, yogurt or calcium-fortified orange juice do you consume daily? _______________________

- Do you take something to help you sleep more than once a week? □ Yes □ No

- Do you restrict your diet in any way? (such as low calorie, low fat, no added salt, etc.) □ Yes □ No

FAMILY HISTORY:

- How many children do you have? □ None Sons ______ Daughters ______

- Are all alive and in good health? □ Yes □ No
  - If no, please explain: _______________________________________________________

- How many siblings do you have? □ None Brothers ______ Sisters ______

- Are they alive and well?
  - Yes □ No
    - If no, please explain: _______________________________________________________

- Is your mother still living? □ Yes □ No
  - If yes, major health problems / If no, cause of death ____________________________________________

- Is your father still living? □ Yes □ No
  - If yes, major health problems / If no, cause of death ____________________________________________

Is there a family history (father mother, sister, brother, or children) of:

- Diabetes
- High Cholesterol
- Heart Attacks before age 65
- Cancer (Prostate, Skin, Breast, Colon, Ovarian)
- Depression
- Suicide
- Alcoholism / Drug Abuse

SYSTEMS REVIEW:

GENERAL – Have you noticed:

- Significant weight change (> 10#) in the past 6 months? □ Yes □ Increase □ Decrease
- Significant recent appetite change? □ Yes □ Increase □ Decrease
- Significant sweating or night sweats? □ Yes □ No

SKIN – Have you had:

- Recent rashes, lumps, or other skin / hair / nail problems? □ Yes □ No
- A history of skin cancer? □ Yes □ No

PLEASE continue to next page – PATIENT HISTORY
PATIENT PHYSICAL HISTORY (Page 3)

SYSTEMS REVIEW (continued):

EYES – Have you had:
  Recent vision changes?  □ Yes  □ No  Last eye appointment: __________ With whom? __________
  Glaucoma/Cataracts?  □ Yes  □ No

EARS / NOSE / MOUTH / THROAT – Have you had:
  Hearing Problems?  □ Yes  □ No; Do you have / use hearing aides?  □ Yes  □ No
  Frequent wax impaction?  □ Yes  □ No
  Frequent nosebleeds?  □ Yes  □ No
  Do you have a history of Obstructive Sleep Apnea?  □ Yes  □ No  If yes, do you use CPAP? __________
  Do you snore so loudly that your bed partner complains about it?  □ Yes  □ No
  Do you have excessive daytime fatigue?  □ Yes  □ No
  Do you notice SIGNIFICANT dizziness, vertigo?  □ Yes  □ No

CARDIOVASCULAR
  Do you get:
  Chest pain / pressure / tightness / squeezing?  □ Yes  □ No
  If yes, does it occur with activity or exertion?  □ Yes  □ No
  Heart fluttering / flip-flops / skipping or palpations?  □ Yes  □ No
  Swelling of ankles?  □ Yes  □ No
  Pain in legs while walking?  □ Yes  □ No
  How far can you walk before you get short of breath?  □ Feet  □ Blocks  □ Miles  □ Unlimited
  Do you take antibiotics before dental work?  □ Yes  □ No
  Do you exercise on a regular basis (more than 2x per week)?  □ Yes  □ No
  If yes, what type of exercise? __________ How often? __________

RESPIRATORY – Have you ever been told that you have:
  Asthma?  □ Yes  □ No
  Emphysema/chronic bronchitis?  □ Yes  □ No
  Blood clots in your leg or lung?  □ Yes  □ No
  Tuberculosis (TB) or positive TB skin test?  □ Yes  □ No
  Do you notice frequent:
    Wheezing / Shortness of breath?  □ Yes  □ No
    Coughing / Phlegm production?  □ Yes  □ No
    Coughing up blood?  □ Yes  □ No

GASTROINTESTINAL – Do you notice:
  Frequent nausea or vomiting?  □ Yes  □ No
  Frequent diarrhea?  □ Yes  □ No
  Significant constipation?  □ Yes  □ No
  Bloody or black bowel movements?  □ Yes  □ No
  Frequent heartburn / regurgitation / indigestion?  □ Yes  □ No
GASTROINTESTINAL (continued):

Do you take antacids or acid blocking agents more than once/week?  □ Yes  □ No
Trouble swallowing / Food getting stuck?  □ Yes  □ No
Have you ever been diagnosed with:  □ Ulcers  □ Hepatitis  □ Colitis

Have you ever had a colonoscopy?  □ Yes  □ No

GENITOURINARY – Do you notice:

Burning / frequency or hesitation with urination?  □ Yes  □ No
Do you wake up more than 2 times /night to urinate?  □ Yes  □ No
Do you have significant difficulty starting your urine stream?  □ Yes  □ No
Dribbling after urination or problems holding your urine?  □ Yes  □ No
Do you have to wear a pad for incontinence more than once/week?  □ Yes  □ No
Have you ever had kidney stones?  □ Yes  □ No

Problems with your sex drive?  □ Yes  □ No
Have you ever had a sexually transmitted disease?  □ Yes  □ No
If yes, what type(s)?  □ Syphilis  □ Gonorrhea  □ Chlamydia  □ Warts
Are you sexually active  □ Yes  □ No; If yes, with:  □ Women?  □ Men?  □ Both?
How many sexual partners have you had in the last 6 months?  __________________________________________

What kind of birth control do you use?  □ Condoms  □ Pills  □ IUD  □ Diaphragm
    □ Tubal ligation  □ Vasectomy  □ None  □ Other
Do you use condoms?  □ Always  □ Most of the time  □ Rarely  □ Never
Have you ever been physically or sexually abused?  □ Yes  □ No
Would you like to discuss this further?  □ Yes  □ No
Do you feel safe in your current home/environment?  □ Yes  □ No

WOMEN: – Do you have or have you had:

Problems related to menopause/change of life?  □ Yes  □ No
An abnormal Pap smear?  □ Yes  □ No; If yes, when __________________________________________
An abnormal mammogram?  □ Yes  □ No; If yes, when __________________________________________
Breast discharge, masses, or cancer?  □ Yes  □ No

MEN:

Do you have difficulty with erections?  □ Yes  □ No
Would you like to discuss this further?  □ Yes  □ No

MUSCULOSKELETAL – Do you have or have you had:

Significant joint pains or arthritis?  □ Yes  □ No  If yes, which joints bother you most?  __________________________
Gout?  □ Yes  □ No  If yes, last episode __________________________
Significant neck pain that bothers you most days?  □ Yes  □ No
Significant low back pain that bothers you most days?  □ Yes  □ No

– Please continue to next page –
NEUROLOGICAL – Do you have or have you had:

- Tremors / shakes? □ Yes □ No
- Significant memory problems? □ Yes □ No
  If yes, does it interfere with functioning? □ Yes □ No
- A significant fall in the past year? □ Yes □ No
- Seizures? □ Yes □ No
- Significant headaches – severe enough to make you go home from school or work? □ Yes □ No
- Blackouts / fainting spells? □ Yes □ No
  If yes, when was your last fainting spell? ___________________________________________________________
- Significant numbness / tingling noted on a daily basis? □ Yes □ No
  If yes, where is the numbness/tingling noted? _________________________________________________________

MENTAL / EMOTIONAL

- In the last 2 weeks, have you felt down, depressed, or hopeless? □ Yes □ No
- Have you recently had little interest or pleasure in doing your day to day activities? □ Yes □ No
- Have you ever had depression so severe that you considered suicide? □ Yes □ No
- Do you feel that you worry excessively to the point where you feel your muscles tighten and/or can’t sleep? □ Yes □ No

Do you drink alcohol? □ Not at all □ Occasionally □ Daily

If you drink alcohol, on any single occasion in the past 3 months have you had more than 5 drinks containing alcohol?
- If yes: On how many days per week do you drink alcohol? _____________________________________________
- On a typical day when you drink, how many drinks do you have? _________________________________
- What is the maximum number of drinks that you had on any given day in the past month? _________

- Have you seen a psychiatrist or therapist in the past? □ Yes □ No
  When were you last seen? ________________________________ By whom ___________________________________

HEMATOLOGIC / LYMPHATIC & ALLERGIC / IMMUNOLOGIC – Have you had:

- Anemia? □ Yes □ No
- Problems with your spleen or had your spleen removed? □ Yes □ No
- Bleeding or clotting problems? □ Yes □ No
- Easy bruising? □ Yes □ No

Do you have:
- Seasonal allergies/hay fever? □ Yes □ No
  If yes, do you take something for this? ___________________________________________________________
- Food, latex or drug allergies? □ Yes □ No
  If yes, from what food and/or drug with what type of reaction? _______________________________________
- Have you ever seen an allergist □ Yes □ No

SOCIAL:

- Do you have a Durable Power of Attorney (DPA) for Health Care, Living Will or other Advanced Directives?
  Would you like information regarding this? □ Yes □ No
- Do you have any other questions or would you like any information about a specific health related topic?

Thank you for taking the time to complete this questionnaire. It helps us provide the best possible health care for you.