Headache History Inventory

Name: DOB: Date:

1. When did your headaches start? _____
2. How often do your headaches occur?
   a. Daily_____ b. Monthly_____
   c. Weekly_____ d. Other _____

3. What is the severity of your headache?
   a. Mild _____ b. Severe _____
   c. Moderate_____ d. Incapacitating_____

4. How would you describe the pain?
   a. Throbbing _____ b. Dull _____
   c. Pulsating _____ d. Nagging _____
   e. Boring _____ f. Tightness _____
   g. Shock-like_____ (hatband distribution)
   h. Stabbing _____ i. Other _____

5. How long does your headache last?
   a. One hour or less_____ b. Constant _____
   c. Two to 24 hours_____ d. Other_____
   e. More than 24 hours ____

6. Are your headaches associated with any other symptoms?
   a. Nausea_____ b. Nasal Congestion_____
   c. Vomiting_____ d. Nasal Discharge_____
   e. Intolerance to light_____ f. Dizziness_____
   g. Aversion to loud sounds_____ h. Tearing of eye _____
   i. Other_____

7. Have any of your family members ever experienced headaches?

   _____ _____
   _____ _____

8 Describe any forewarning that your headache is about to start:

_____
_____

_____

Onset of headache:
Time interval between onset of pain and maximal intensity of pain:
_____Minutes _____Hours

Factors that trigger headaches: □ Food □ Alcohol
□ Too much sleep □ Allergies □ Menstrual Periods
□ Medications □ Other trigger factors:_____

Habits: Number of cups of coffee/day_____
Soft drinks_____ Iced tea _____

CT/MRI Scans: Did you ever have scans of brain in the past?
□ CT Scan □ MRI Scan Year_____

Sleep:
Usual bed time __:__pm/am Usual wake up time __:__am/pm
Time taken to fall asleep_____minutes/hours.
□ Frequently wake up during sleep or early morning hours?
□ Do you snore during sleep? □ Do you have headaches upon waking?
□ Does your spouse complain about excessive leg movements during sleep?
□ Do you fall asleep easily through the day at work?

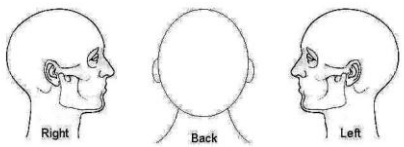
Have you seen any other physician for headaches?
□ Neurologist/ Allergist/ Pain Management Specialist/ Chiropractor
Mention year seen, treatment, and investigation. _____

_____

Check if you have any of the following symptoms: □ Fatigue

□ Poor Concentration	□ Memory Difficulties	□ Loss of Appetite
□ Increased Appetite	□ Weight Gain	□ Weight Loss
□ Depressed Mood	□ Anxiety	□ Loss of Interest
□ Sleeping too Much	□ Inability to sleep	□ Frequent Awakenings during Sleep

Last Eye Exam: □ Normal
Details if abnormal: _____



Indicate the location of your headache pain on these diagrams.

NAME:_____ DATE: _____

Please check all the medicines on this list that you have taken for headaches, indicating dose and duration.

X	DRUG	CURRENTLY TAKING?
	Advil (Ibuprofen)	Y N
	Aleve (Naprosyn)	Y N
	Anaprox	Y N
	Aspirin	Y N
	Axocet	Y N
	Buprenex	Y N
	BC Powder	Y N
	Cataflam	Y N
	Darvocet N100	Y N
	Darvocet N50	Y N
	Daypro	Y N
	Demorol Tablets	Y N
	Demorol Inject	Y N
	Duragesic	Y N
	Ecotrin	Y N
	Excedrin	Y N
	Esgic Plus	Y N
	Fioricet	Y N
	Fioricet Codeine	Y N
	Fiorinal	Y N
	Indocin	Y N
	Lodine	Y N
	Lorcet 10/650	Y N
	Lortab	Y N
	Midrin	Y N
	Motrin	Y N
	Naprosyn	Y N
	Norgesic	Y N
	Orudis	Y N
	Percocet	Y N
	Percodan	Y N
	Phrenalin	Y N
	Phrenalin Forte	Y N
	Relafen	Y N
	Stadol	Y N
	Talwin	Y N
	Torado	Y N
	Tylenol	Y N
	Ultram	Y N
	Vicodin	Y N
	Hydrocodone	Y N
	Methadone	Y N

X	DRUG	CURRENTLY TAKING?

	Imitriex Inject	Y N
	Imitrex Nasal	Y N
	Zomig Tablet	Y N
	Zomig Nasal	Y N
	Frova	Y N
	Axert	Y N
	Relpax	Y N
	Maxalt	Y N
	Cafergot	Y N
	Migranol	Y N
	DHE Injection	Y N
	Duradrin	Y N
	Amerge	Y N
	Elavil	Y N
	Amitryptilene	Y N
	Pamelor	Y N
	Nortriptylene	Y N
	Vivactil	Y N
	Prozac	Y N
	Effexor	Y N
	Serzone	Y N
	Zoloft	Y N
	Trazadone	Y N
	Paxil	Y N
	Depakote	Y N
	Inderal	Y N
	Calan	Y N
	Lithium	Y N
	Neurontin	Y N
	Celexa	Y N
	Topamax	Y N
	Celebrex	Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N