NAME:

Headache onset: most recent? lifetime?

Headache frequency (HA days/month)?

How many different types of headaches? (If more than one headache indicate for each “a”, “b”, “c”)

Headache intensity: (mild, moderate, severe)

Headache duration: (minutes, <3hours, >3hours, days)

Headache quality: (pressure, tightness, throbbing, piercing, boring, ice-pick)

Headache location: (unilateral, bilateral, frontal, temporal, occipital, cervical.)

Headache associated symptoms: (nausea/vomiting light, sound, smell sensitivity)

**Migraine triggers:*

**Migraine aura: (visual, sensory, equilibrium, motor, language)*

aura symptoms (before, during, after) headache?

**Menstrual History: how often are your periods regular?*
are your headaches associated with your period (before, during, after)?
if not regular, when did your periods change? or stop?

GENERAL MEDICAL HISTORY:

hypertension	liver disease	anxiety disorder	stroke	**other:**
heart disease	peptic ulcer	panic attacks	seizures	
diabetes	irritable bowel	bipolar	neuropathy	
rheumatoid/ arthritis	thyroid disease	depression	MS	
	asthma		Parkinsons	

Past Surgical History:

Family History: (migraine…seizure….stroke…depression)

HABITS: smoking- caffeine(coffee,tea,soda) alcohol sleep problems-

MEDICATIONS: (dose/ current and past medex)

1.	4.	7.	over-the-counter-meds (#pills/day):
2.	5.	8.	
3.	6.	9.	

RADIOLOGY EXAMS (CT….MRI….EEG)