UB|MD NEUROLOGY

Name: _____

DOB: _____

HEADACHE CLINIC INTAKE FORM

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PLEASE BRING TO FIRST APPT.

ARE YOU RIGHT HANDED OR LEFT HANDED? (check one) ☐ AMB. ☐ RIGHT ☐ LEFT

PAST MEDICAL PROBLEMS AND SURGERIES:

_____

_____

_____

_____

_____

CURRENT MEDICATIONS:

Medication:	Dose:	Frequency:

MEDICATION ALLERGIES:

_____

_____

_____

_____

_____

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FAMILY HISTORY:

Please indicate if any family members area affected with the following:

Condition	YES or NO		Type/Affected Relative
Brain Tumor	☐	☐	_____
Aneurysm	☐	☐	_____
Migraine	☐	☐	_____
Sinus Problems	☐	☐	_____

Write other neurological conditions: _____

_____

_____

_____

_____

SOCIAL HISTORY:

Occupation: _____

Marital Status: _____

Highest Level of Education: _____

Have you ever smoked tobacco? _____ If yes, do you currently smoke _____

Do you drink alcohol? _____If yes, how many drinks per week? _____ Does alcohol trigger headaches?____

Do you use recreational drugs?_____ If yes. Please indicate which drugs _____

Do you snore? _____If yes, have you had a sleep study/ when? _____

Females:

Are you or could you be pregnant? (check one) ☐ Yes ☐ No

Do you have regular menstrual cycles? (check one) ☐ Yes ☐ No

Do you use hormones or other contraceptives? (check one) ☐ Yes ☐ No

If yes, what kind? _____ Started? _____

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HEADACHE NUMBERS:

Please mark N/A to any question that does not apply.

1. How many days out of the last **MONTH** did you have absolutely **NO** headache? _____
2. How many days in the last **MONTH** did you experience **ANY** kind of headache? _____
3. How many days in the last **MONTH** have you had a **SEVERE** headache? _____
4. How many days in the last **MONTH** did your headache completely stop your activity? _____
5. How many trips to the emergency room for headaches in the past **THREE** months? _____
6. How many missed days of work in the past **THREE** months? _____

Please sign and date below:

The information on this form is accurate to the best of my knowledge

_____ _____

Patient Signature Date Completed

I have reviewed the above information with the patient.

_____ _____

Physician Signature Date Reviewed

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PRIOR THERAPY

(Check those that you have been on & list any side effects, dose/ duration of treatment if known)

BETA BLOCKERS ☐ Atenolol (Tenormin) ☐ Metoprolol (Lopressor) ☐ Nadolol (Corgard) ☐ Propranolol (Inderal) ☐ Other: _____	SEROTONIN ANTAGONISTS ☐ Cyproheptadine (Perectin) ☐ Other: _____
CALCIUM CHANNEL BLOCKERS ☐ Amlodipine (Norvasc) ☐ Diltiazem (Cardizem) ☐ Nifedipine (Procardia) ☐ Verapamil (Calan) ☐ Other: _____	ANTICONVULSANTS ☐ Carbamazepine (Tegretol) ☐ Phenytoin (Dilantin) ☐ Divalproex Sodium (Depakote) ☐ Gabapentin (Neurontin) ☐ Levetiracetam (Keppra) ☐ Phenobarbital ☐ Lamotrigine (Lamictal) ☐ Topiramate (Topamax) ☐ Zonisamide (Zonegran) ☐ Other: _____
ANTIDEPRESSANTS ☐ Amitriptyline (Elavil) ☐ Desipramine (Norpramin) ☐ Doxepin ☐ Imipramine ☐ Nortriptyline ☐ Trazodone ☐ Remeron ☐ Other: _____	MUSCLE RELAXANTS ☐ Baclofen (Lioresal) ☐ Carisoprodol (Soma) ☐ Cyclobenzaprine (Flexeril) ☐ Orphenadrine (Norflex) ☐ Tizanidine (Zanaflex) ☐ Other: _____
ACE INHIBITORS ☐ Captopril (Capoten) ☐ Enalapril (Vasotec) ☐ Lisinopril (Zestril) ☐ Candesartan (Atacand) ☐ Other: _____	MAO INHABITORS ☐ Isiocarbixazid (Marplan) ☐ Phenelzine (Nardil) ☐ Tranylcypromine (Parnate) ☐ Other: _____
ALPHA-ADRENERGIC BLOCKERS ☐ Clonidine (Catapres) ☐ Doxazosin (Caradura) ☐ Other: _____	DIURETIC ☐ Acetazolamide (Diamox) ☐ Other: _____
CO X2 ☐ Celexcoxib (Celebrex) ☐ Other: _____	

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SUPPLEMENTS ☐ Co Q 10 ☐ Vitamin B 2/Pyridoxine ☐ Feverfew ☐ Magnesium ☐ Petadolex ☐ Migrelieve ☐ Melatonin	TOXINS ☐ Onabotulinumtoxina (Botox)
NSAIDS ☐ Aspirin ☐ Diclofenac (Voltaren, Cambria) ☐ Etodolac (Lodine) ☐ Ibuprofen (Motrin) ☐ Indomethacin (Indocin) ☐ Ketoprofen (Orudis) ☐ Ketorolac (Toradol) ☐ Naproxen Sodium (Naprosyn) ☐ Other: _____	ANALGESICS & OVER THE COUNTER ☐ Acetaminophen/ Caffeine/ Butal (Floricet) ☐ ASA/ Caffeine/ Butalbital (Flornial) ☐ Isometheptene/ Acet/ Dichloral (Midrin) ☐ Acetominophen (Tylenol) ☐ Acetamin/ ASA/ Caffeine (Excedrin) ☐ Decongestants (Sudafed) ☐ Other OTC: _____
BENZODIAZEPINES/ TRANQUILIZERS ☐ Alorazikan (Xanax) ☐ Buspirone (Buspar) ☐ Clonazepam (Klonopin) ☐ Lorazepam (Ativan) ☐ Zolpidem (Ambien) ☐ Diazepam (Valium) ☐ Other: _____	NARCOTICS/ OPIODS ☐ Butorphanol (Stadol) ☐ Fentanyl (Duragesic) ☐ Codeine (Floricet w/codeine) ☐ Meperidine (Demerol) ☐ Long acting Oxycodone (Oxycontin) ☐ Oxycodone (Percocet) ☐ Tramadol (Ultram) ☐ Other: _____
TRIPTANS ☐ Almotriptan (Axert) ☐ Frovatriptan (Frova) ☐ Naratriptan (Amerge) ☐ Rizatriptan (Maxalt) ☐ Sumatriptan (Imitrex) ☐ Zolmitriptan (Zomig) ☐ Eletriptan (Relpax) ☐ Other: _____	ANTI-NAUSEA ☐ Meclizine (Antivert) ☐ Metolopramide (Regain) ☐ Prochlorperazine (Compazine) ☐ Promethazine (Phenegran) ☐ Ondansetron (Zofran) ☐ Other: _____
ERGOTS ☐ Bromocriptine (Palodel) ☐ Dihydroergotamine (DHE) ☐ Methylergonovine (Methergine) ☐ Inhaled DHE (Migranal) ☐ Other: _____	HOMRMONES ☐ Estrogen/ Progesterone (Many OCPs) ☐ Estrogen (Premarin) ☐ Medroxyprogesterone (Provera) ☐ Other: _____
STERIODS ☐ Dexamethasone (decadron, Medrol) ☐ Prednisone (Deltasone) ☐ Other: _____	ANTIPSYCHOTIC ☐ Quetiaphine (Seroquel) ☐ Resperidone (Risperdal) ☐ Other: _____