We first want to know about headaches you may have had earlier in your life:

Date: _____________________________________

1. When I had my first noticeable headache, I was _______ years old.

2. As far as I can remember, these headaches (check all that apply):
   □ lasted several hours to days and made me sick  □ were associated with visual symptoms or tingling
   □ were constant from the beginning

Now, we want to know about the worst type of headaches that you have now:

3. The headaches that I have now started ___________ years/months ago.

4. They usually last:
   □ ___________ minutes/hours/days
   □ they are constant (I always have a headache)
   □ on/off, they seem to have no pattern

5. The headaches go along with:
   □ nausea  □ vomiting  □ red eye  □ eye tearing  □ light sensitivity
   □ sound sensitivity  □ runny nose  □ ____________________________________________

6. Before or during the headaches I:
   □ see zigzag lines  □ see shimmering lights
   □ feel tingling (where _______________?)

   This usually lasts □ for ___________ minutes/hours  □ for the entire headache

7. During the headache, I go to bed or try to avoid physical activity (for instance, going up a flight of stairs)
   □ Yes  □ No

8. The headaches are usually located (circle):
   - R
   - L
   - Left
   - Right

9. The headaches are usually:
   □ stabbing  □ pounding  □ pulsating  □ burning  □ pressure/vice like
   □ like a knife  □ other ___________________________

10. The headaches can be triggered by:
    □ coughing  □ sneezing  □ having a bowel movement  □ exercise
    □ oversleeping  □ not sleeping enough  □ weather change  □ sexual activity
    □ certain foods ____________________________  □ ____________________________________________

11. Did you ever have headaches that were clearly triggered by getting into upright position, and stopped just from laying flat a few minutes (positional headaches)? □ Yes □ No
12. Over the past 2 months, due to headaches, I missed _____ days of work, and I went to the ER (Emergency Room) _______ times

13. Medical History: _______________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

14. Surgical History: ________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

15. Family History

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Migraines or other strong headaches (✓)</th>
<th>Other important medical problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
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<tr>
<td>Mother</td>
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<tr>
<td>Brother/sister</td>
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<td>Child</td>
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<td>Child</td>
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</tbody>
</table>

16. On average, I drink about ____________ caffeinated beverages per day.

17. □ I never smoked □ I smoke or did smoke _____ (packs of cigarettes/cigars/pipes) per day for ______ yrs

   If applicable, date that you quit smoking _____/_____/_____
18. I have __________ alcoholic drink(s) per day/week/month

19. I had (or currently have) a problem with alcohol or drugs  □ Yes □ No

20. I use or did use recreational drugs: □ Cannabis □ Cocaine □ Heroin □ Amphetamines □ Other ________

21. Do you have problems with any of the following, now or recently, related to the headaches or completely unrelated? Please place a √ and explain details if needed.

- □ Heart (e.g. funny heart beats, chest pain)
- □ Lungs (cough, shortness of breath)
- □ Bowel or bladder
- □ Skin
- □ Hearing (e.g. hearing loss, ear noise)
- □ Vision/eyes (e.g. double vision)
- □ Mind/mood (anxiety, depression)
- □ Balance
- □ Memory/concentration/cognition
- □ Numbness, tingling
- □ Involuntary weight loss, fatigue
- □ Joint pain or swelling
- □ Swollen glands
- □ Jaw/chewing
- □ Pain elsewhere
- □ Other

22. Which doctors have been involved in treating your headaches so far? ______________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

23. Which tests/scans did you undergo so far, if any: ____________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

24. What do you think is causing your headaches, or what do you suspect is your diagnosis? __________________
______________________________________________________________________________________________
______________________________________________________________________________________________

25. What do you expect from this visit? __________________________________________________________________
______________________________________________________________________________________________
26. What medications did you try for your headaches?

Acute/abortive drugs (medications that you take in order to stop the headache that you have right now) that you took for headaches:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Result (NE= not effective, NT= not tolerated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ibuprofen (Advil TM)</td>
<td></td>
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<tr>
<td>Hydrocodone/APAP (Vicodin TM, Norco TM)</td>
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<tr>
<td>Ketorolac (Toradol TM)</td>
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<tr>
<td>Sumatriptan (Imitrex TM) tablets</td>
<td></td>
<td></td>
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<tr>
<td>Sumatriptan (Imitrex TM) injection</td>
<td>4 mg</td>
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<td></td>
<td>6 mg</td>
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<tr>
<td>Zolmitriptan (Zomig TM)</td>
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<tr>
<td>Almotriptan (Axert TM)</td>
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<tr>
<td>Rizatriptan (Maxalt TM)</td>
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<tr>
<td>Eletriptan (Relpax TM)</td>
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<tr>
<td>DHE (Migranal TM)</td>
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<tr>
<td>Treximet TM</td>
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</tbody>
</table>

Preventive drugs (medications that you take/took every day for your headaches, regardless of whether you have a headache that day or not):

<table>
<thead>
<tr>
<th>Drug</th>
<th>Max. dose per day</th>
<th>Tried for how many months/weeks</th>
<th>Result (NE= not effective, NT= not tolerated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topiramate (Topamax TM)</td>
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<tr>
<td>Valproate (Depakote TM)</td>
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<tr>
<td>Propranolol or other beta blocker</td>
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<tr>
<td>Verapamil (Isoptin TM)</td>
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<tr>
<td>Amitriptyline or Nortriptyline</td>
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<tr>
<td>Lithium</td>
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<tr>
<td>Prednisone or other steroids</td>
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<tr>
<td>Gabapentin</td>
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</tbody>
</table>

Completed by: ________________________________________________________________ Date: ___________________

If not completed by patient, relationship to patient: _________________________________________________________

Reviewed by: _______________________________________________ Date: _________ Time: __________