Ravi S Gill, MD

Headache / Migraine Evaluation

Name ______________________ D.O.B ______________________ Date __________

Medical History

Please check or fill in the correct answer to each of the following that applies:

At what age did your headaches begin? ______________________

Does anyone else in your immediate family have headaches? ❑ Yes ❑ No If yes, please specify ______________________

Describe a typical headache episode you have recently had: ______________________

How would you rate the physical discomfort you experienced?

❑ Very mild ❑ Mild ❑ Uncomfortable, but not painful ❑ Painful ❑ Extremely painful

How frequently do you have headaches?

❑ Daily ❑ Weekly ❑ Monthly ❑ Other

Do your headaches result in lost time at work or your normal daily activities? ❑ Yes ❑ No ❑ Sometimes

Symptoms

Which of the following do you associate with a typical headache?

❑ Dull, Nonthrobbing pain ______ ❑ Pain on one side of head ______ ❑ Daily headaches ______

❑ Pain that lasts for days at a time ______ ❑ Throbbing, pulsating pain ______ ❑ Pain occurring at night ______

❑ Pain on both sides of head ______ ❑ Nausea ______ ❑ Intense pain behind or around one eye

❑ Tightening of muscles in head, face and neck ______ ❑ Vomiting ______ ❑ Pain that causes awakening from sleep

❑ Chest pain ______ ❑ Sensitivity to light ______ ❑ Nasal drainage ______

❑ Tight skull cap sensation ______ ❑ Sensitivity to sound ______ ❑ Tearing ______

❑ Pain in face (forehead, cheeks, behind eyes, across nose) ______ ❑ Dizziness ______ ❑ Eyelid drooping ______

❑ Gnawing pain in nasal area ______ ❑ Cold hands ______ ❑ Nasal congestion ______

❑ Pain that increases during the day ______ ❑ Tremors ______

❑ Piercing, burning pain on one side of head or behind eyes ______

Have any of the following accompanied a headache?

❑ Numbness ______ ❑ Muscle weakness ______ ❑ Stiff neck ______

❑ Fever ______ ❑ Shortness of breath ______ ❑ Memory loss and confusion ______

❑ Head injury ______ ❑ Severe vomiting ______ ❑ Other ______

After taking your migraine / headache medication, does nausea or vomiting occur immediately?

____

Approximately when did your last headache occur? ______________________

On average, how long does each headache last? ______________________

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Ravi S Gill, MD

HEADACHE / MIGRAINE EVALUATION

Name ______________________________ Date ____________

SYMPTOMS

Of the following, which seems to bring on a headache?

- ❑ Menstruation ____________
- ❑ Alcohol ____________
- ❑ Certain Foods ____________
- ❑ Exercise ____________
- ❑ Bright light or glare ____________
- ❑ Hunger ____________
- ❑ Stress ____________
- ❑ Certain odors ____________
- ❑ Change in sleeping habits
- ❑ Smoking ____________
- ❑ Excessive noise ____________
- ❑ Medications ____________
- ❑ Relaxation after stress ____________
- ❑ Too much sleep ____________
- ❑ Too little sleep ____________
- ❑ Change in weather ____________
- ❑ Food additives (MSG, etc.) ____________
- ❑ Other ____________

Have you experienced warning signs of oncoming headaches? ❑ Yes ❑ No

If yes, which if the following describes your typical warning sign?

- ❑ Distorted vision (such as flickering points of light or jagged lines) ____________
- ❑ Changes in mood ____________
- ❑ Changes in appetite ____________
- ❑ Other ____________

____

TREATMENT MEDICATION

Do any of the following relieve your headache pain?

- ❑ Lying down in a quit darkened room ____________
- ❑ OTC decongestants ____________
- ❑ Applying alternating hot/cold packs ____________
- ❑ Hot shower ____________
- ❑ Deep massage of head, neck and shoulders ____________
- ❑ Other ____________

Which over-the-counter medications have you taken for headaches (Examples: aspirin, acetaminophen, ibuprofen)? ____________

____

How many OTC pills do you take a day? ❑ 1 - 2 ❑ 3 - 4 ❑ 5+

How well do they work? ____________

Have you noticed an increase in the frequency of your headaches when you increase your medications? ❑ Yes ❑ No

Which prescription medications have you taken for your headaches? ____________

How well do they work? ____________

How frequently do you take them? ____________

Have you ever tried any other treatments such as biofeedback or oxygen inhalation? ❑ Yes ❑ No

If Yes, Please specify: ____________

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How well did this treatment work? ____________

If female, have you ever noticed a connection between your menstruation periods and headaches? ❑ Yes ❑ No

COMMENTS

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