HEADACHE HISTORY & PROFILE

NAME DATE OF BIRTH DATE

On what part of the head do the headaches start? Use diagrams to indicate -

___ (R) Side ___ (L) Side ___ Either side ___ Both sides
___ Back ___ On top ___ Temples ___ Behind / around eyes
___ Forehead ___ Face ___ Neck ___ Other -

After the headache starts - Does it usually - Stay in one place _____ Move around _____ Please explain -

How would you describe the pain? ___ Throbbing / pulsating ___ Pressing / squeezing ___ Stabbing ___ Sharp
___ Dull / nagging ___ Other -

Describe the degree of pain (circle one #) - slight - 1 2 3 4 5 6 7 8 9 10 - worst imaginable

Do your headaches interfere or prevent normal activities - work etc.? ☐ Yes ☐ No

How long ago did the current headaches start? ___ Weeks ___ Months ___ Years

How old were you when any headache started? ___

How long does the headache usually last? ___ Minutes ___ Hours ___ Days ___ Constant

How often does the headache occur? ___ x / Day ___ x / Week ___ x / Month ___ x / Year ___ Constant

Does the headache awaken you from sleep? ☐ Yes ☐ No

Is the headache getting ___ worse ___ better ___ fluctuating ___ no change

Are any of the following symptoms associated with the headache? *Please mark* ***(B)*** *before* ***(✓)*** *during* ***(A)*** *after*

___ Spots before eyes - type
___ Blindness (R L)
___ Blurring (R L)
___ Double vision
___ Can see only half of objects
___ Eyelid droop (R L)
___ Tearing (R L)
___ Eye redness (R L)
___ Eyes puffy (R L)
___ Light sensitivity
___ Noise sensitivity
___ Odors sensitivity
___ Nose blocked / discharge (R L)

___ Nausea ___ Vomiting
___ Loss of appetite ___ Hunger
___ Cramps ___ Diarrhea

Face - Scalp -
___ Pale ___ Redness
___ Sweating ___ Tender
___ Puffy ___ Pain on chewing
___ Decreased jaw opening

Neck -
___ Stiff ___ Tender

___ Difficulty concentrating
___ Depression ___ Anxiety
___ Fatigue ___ Irritability

Weakness(W) Numbness(N) Both(B)
___ Face (R L) ___ Arms (R L)
___ Arm & Leg (R L) ___ Legs (R L)

___ Difficulty talking (finding words)
___ Difficulty understanding
___ Numbness around lips
___ Slurred speech
___ Fainting (feel like or have fainted)
___ Dizzy (lightheaded - unsteady) - spinning)

Hands and / or feet -
___ Cold ___ Pale
___ Sweaty ___ Mottled

HEADACHE HISTORY & PROFILE - *(CONTINUED)*

Indicate if any of the following factors have (✓) brought on (trigger) **or** (x) worsen your headache -

___ Head injury
___ Sleep - too much - too little
___ Emotional stress ___ during ___ after
___ Depression - anxiety
___ Physical activity
___ Erect position
___ Bending over
___ Straining - coughing

___ Sexual activity
___ Missed meal
___ Change in weather
___ Seasons -
___ Alcohol ___ MSG
___ Processed meats
___ Chocolate ___ Citrus fruits
___ Cheeses

___ Other foods _____
_____
_____
___ Medications _____
_____
___ Menstrual periods
___ Pregnancy ___ Menopause
___ Contraceptives

Do any blood relatives have severe headaches? ☐ Yes ☐ No - Who & Diagnosis -

Which of the following makes the headache better? ___ Rest ___ Activity ___ Darkness ___ Quiet ___ Compresses ___ Scalp or temple pressure ___ Pregnancy ___ Menopause

Personal History - Cig (# / day / # yrs) Alcohol (oz. / day) Coffee (cups / day)

Are you or have been - ____ Depressed ____ Anxious

Previous professional treatment of headache? ☐ Yes ☐ No - Who & When -

Previous x-ray or other investigations of headache? ☐ Yes ☐ No - Describe -

Previous medications for headache? ☐ Yes ☐ No - Name - dosage

Other current medications? Please list - include over-the-counter drugs

DRUG ALLERGIES

MIDAS HEADACHE DISABILITY SCORE:

ADDITIONAL NOTES