Headache Revisit Evaluation

Name _____
Date_____

Please answer <u>all</u> of the following questions. If you are uncertain, give your best guess.

Circle the number that best describes the change in your headaches since you were *first* treated here.

0 1 2 3 4 Same 6 7 8 9 10 (headache free)
Worsened ---------- Improved

Circle the number that best describes the change in your headaches since your *last* visit here.

0 1 2 3 4 Same 6 7 8 9 10 (headache free)
Worsened ---------- Improved

- **How many days in the last 4 weeks (28 days) did you have: (Total must equal 28 days)**
  Severe headaches _____ Moderate headaches_____ Mild headaches_____ No headache_____

- **How many days in the last 4 weeks (28 days) did you need to take migraine or pain medications?**
  (0-28) _____ (Do not count preventive medications)

- **During the past 4 weeks, how different would your life have been without headaches?**
  1. completely different, 2. very different, 3. somewhat different, 4. not much different, 5. not at all different

1. When you have headaches, how often is the pain severe?	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
2. How often do headaches limit your ability to do usual daily activities including housework, work, school, or social activities?	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
3. When you have a headache, how often do you wish you could lie down?	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
4. In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
5. In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
6. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
TOTAL:	**6**	**8**	**10**	**11**	**13**

Please list **ONLY** medications used in the past 4 wks. **THAT HAVE BEEN PRESCRIBED BY THE HEADACHE WELLNESS CENTER**

name/dose	#used/month	name/dose	#used/month

Please list any **OTHER** medications (prescription from other physicians, over-the-counter & supplements) used in the past 4 wks.

name/dose			

List ALL your drug allergies: _____

Staff Notes:

Wt _____ Height _____ BP _____/_____ P _____ Dictated _____

OVER

Describe any change in your medical, surgical or emotional (stress) condition since you were last seen:

Check (✓) symptoms which have occurred recently

GENERAL
__ appetite change
__ chills
__ abnormal sweating
__ low energy
__ fatigue
__ fever
__ lethargy
__ recent weight change

EYES
__ discharge
__ drooping
__glaucoma
__ eye pain
__ contact lenses
__ abnormal vision

EARS, NOSE, THROAT
__ ear pain
__ ear discharge
__ abnormal hearing
__ buzzing, ringing
__ vertigo
__ nasal discharge, blood
__ hay fever, allergies
__ nasal congestion
__ sinus problems
__ snoring
__ problems with teeth
__ mouth pain
__ hoarseness
__ sore throat
__ tongue pain, burning

HEART
__ chest pain
__ swelling ankles/feet
__ heart murmur
__ high blood pressure
__ irregular or rapid heart
__ heart disease
__ high cholesterol

RESPIRATORY
__ asthma
__ bronchitis
__ cough
__ coughing up blood
__ abnormal sputum
__ shortness of breath
__ wheezing

GI
__ abdominal pain
__ abdominal swelling
__ constipation
__ diarrhea
__ abnormal "gas"
__ food intolerance
__ heartburn
__ ulcers
__ hepatitis
__ liver abnormality
__ nausea or vomiting
__ regurgitation
__ bloody or black stools
__ trouble swallowing

GU
__ abnormal periods
__ abnormal sexual interest
__ poor sexual function
__ sex related disease
__ HIV
__ loss of urine control
__ bloody or dark urine
__ increased urination
__ urine infections
__ pain with urination
__ kidney stones

SKIN
__ sensitivity to sunlight
__ change in moles
__ change in hair
__ skin abnormality/rash
__ breast lump/discharge

NEUROLOGICAL
__ walking abnormalities
__ decreased balance
__ blackouts
__ abnormal sensations
__ abnormal thinking
__ seizures/convulsions
__ dizziness/lightheaded
__ fainting
__ memory loss
__ numbness/tingling
__ speech abnormality
__ tremors

MUSCULOSKELETAL
__ arthritis
__ joint abnormalities
__ back pain
__ arm/leg pain
__ muscle weakness
__ muscle pain/cramps

ENDOCRINE
__ thyroid disease
__ sugar diabetes
__ hormone abnormality

PSYCHIATRIC
__ personality change
__ depression
__ sadness, crying
__ compulsive behaviors
__ fussy/irritable/hostile
__ mood swings
__ restless
__ sleep abnormalities
__ stress/tension
__ eating abnormalities
__ hyperactive
__ abnormal behaviors

HEMATOLOGIC
__ anemia
__ abnormal bleeding
__ abnormal bruising
__ swollen nodes

OTHER

Daily Beverages: Coffee _____cups/mugs; Tea _____cups/glasses; Soda ____glasses/cans
Do your beverages contain caffeine? Yes No
Tobacco use: Yes No (Amount_____)
Do you exercise? Yes No (_____times/week)
Do you sleep well? Yes No Trouble falling asleep? Yes No Trouble staying asleep? Yes No
Do you awaken well rested? Yes No