

Headache Revisit Evaluation

Name _____
Date _____

Please answer all 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
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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	# used/month	name/dose	#used/month
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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