PROVIDENCE ENT
A TRADITION OF EXCELLENCE
A COMMITMENT TO CARING

Patient Name: _____ Date Of Birth: _____
Headache Features:
Age at onset of headache: _____
Frequency of headaches per month: _____

Duration:
___ Up to 3 days
___ Up to 2 weeks

Type:
___ One sided
___ Both sides

Character:
___ Pulsatile, throbbing
___ Non pulsatile, non throbbing

Location of Pain:
___ Eye
___ Neck
___ Face
___ Ear
___ Forehead
___ Teeth

Pain:
___ Moderate to severe
___ Mild to moderate
___ Worse on physical activity
___ No worse on physical activity
___ Nausea/vomiting
___ No nausea/vomiting
___ Sensitivity to sound
___ No sensitivity to sound
___ Sensitivity to light
___ No sensitivity to light

Do you get any warnings prior to your headache?
___ Cravings for sweets
___ Neck pain
___ Flashing lights
___ Yawning
___ Visual Disturbances

Are there any triggering mechanisms for your headaches?
Foods: Cheese ___ Chocolate ____ Citrus ____
Beverages: Caffeine ___ Alcohol ___
Stress ___
Changes in behavior:
- ___ Under/over sleeping
- ___ Change in diet
- ___ Missing meals
- ___ Menstruation

Chronic Daily Headaches:
Occurs:
- ___ Less than 5 days a month
- ___ More than 5 days a month
- ___ 10 days or more a month
- ___ 15 days or more a month

Lasts:
- ___ Over 4 hours/day
- ___ Never goes away
- ___ Has associated eye tearing or nose running
- ___ On and off

Associated Problems:
___ Temporomandibular Joint Disease (TMJ)
___ Depression
___ Anxiety
___ Panic attacks
___ Irritable Bowl Syndrome
___ Sleep Disturbances
___ Fibromyalgia

Clusters of Headaches:
___ Multiple headaches/day
___ Same time each day
___ One sided
___ Rapid progression 5-15 minutes
___ Short duration 45-90 minutes
___ Agitation or relentlessness
___ Running nose
___ Eye tearing
___ Nasal stuffiness

Headache Signs for Concern:
Systemic Symptoms:
- ___ Fever
- ___ Weight loss

Neurological Signs or Symptoms:

___ Confusion

___ Impairment of Alertness ___ Vision ___ Consciousness

Onset: After age 50 ___

Mood and Lifestyle:

Have you ever experienced an extremely traumatic event that included actual or threatened death to you or someone else? (e.g. serious accident, sexual or physical assault, sudden unexpected death of someone close to you, or natural disaster)?

___ yes ___ no

If yes, during the past month have you re-experienced the event in a distressing way(such as dreams, flashbacks, or physical reactions)? ___ yes ___ no

Have you ever been abused physically or sexually as an adult or child? __ yes __ no

Has violence ever been a problem in your household or family? ___ yes ___ no

What are the current stresses or hassles in your life?

___ spouse/partner/relationship

___ Kids

___ Parents

___ Job

___ School

___Other_____

Have there been any major changes in your life in the last few years such as:

___ Loss of job

___ Divorce or end of relationship

___ Major problem with spouse/family

___ Other

specify:_____

Have you ever had a week or more of sustained, unusually elevated mood, like a "high" out of control behavior ,such as risky sex, over spending, racing thoughts and little need for sleep? ___ yes ____ no

Have you ever had a week or more of sustained, excessively irritable mood, with anger, arguments, or breaking things that led to difficulties with others? ___ yes ____ no

Has any close blood relative ever had depression, manic depression, alcohol abuse, or been psychiatrically hospitalized?___ yes ____ no

Is there a change in headache frequency, severity or features in your previous headache history? ___ yes ____ no

Have you ever had?

___ Coronary artery disease
___ Chest pain, angina, stroke
___ Hypertension
___ Elevated cholesterol
___ Overweight
___ Diabetes
___ Smoker
___ Kidney Impairment
___ Liver Impairment
___ Pregnant, or about to become pregnant

List all current headache medications and dosages, including non prescription medication.

Previous Medications and dosage for headache:

Foods/Drinks:
Caffeine intake: Amount ? _____

___Energy drinks
___ Coffee
___ Tea
___ Soda

___MSG (monosodium glutamate) ___ Chinese food
___Diet Foods/Drinks with aspartame or NutraSweet
Family history of headache:

___ Yes Relationship: _____ Type: _____
___ No

Testing done:

___ CAT scan: Where: _____ When: _____
___MRI: Where: _____ When: _____
___Blood: Where: _____ When: _____

Patient Signature: _____ Date: _____
Reviewed by: _____ Date: _____