

ALLERGY & ASTHMA SPECIALISTS, P.A.

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Name _____ Sex _____ Age _____ Occupation _____

DOB _____ DOS _____ Marital status _____ Number of children _____

Referring Physician _____

How many types of headaches do you have? _____

When did your headaches first start? _____

Are you aware of any event or circumstances that seemed to precipitate when your headaches first started?

How often do you get headaches? _____

Does anything trigger your headaches? _____

Do you have any warning that a headache is about to occur? (Describe)

Describe the pain as to:

PATTERN: Have you noted any time of the day, week, month, or year when your headaches appear?

LOCATION: Where is the pain? _____

PROGRESSION: Does the pain move from one area to another?

QUALITY: Describe the pain? (pressure, stabbing, sharp, etc.)

Which of the following precede or accompany your headaches (circle):

Light sensitivity

Noise sensitivity

Runny nose

Stuffy nose

Red eyes

Watery eyes

Itchy eyes

Unsteadiness

Nausea

Vomiting

Diarrhea

Constipation

Blind spots

Flashes of light

Blurred vision

Difficulty swallowing

Difficulty with speech

Dizziness

Numbness or tingling: where? _____

How many cups of coffee, tea, or cola do you drink per day? _____

If female, do your headaches have any relationship to your menstrual cycle or pregnancies?

Name _____

DOB _____ DOS _____

How long do these headaches last if you take medications? _____

How long do these headaches last if you do NOT take medications? _____

How many hours of sleep do you normally get each night? _____

Do you sleep soundly? _____

Do you ever awaken with a headache? _____

Does a headache ever awaken you from a sound sleep? _____

Does a headache ever prevent you from falling asleep? _____

What medications have you taken in the past to prevent headaches?

What medications have you taken in the past to treat headaches once they occur?

What medications do you currently take? Dosage and how often.

What other methods do you use to prevent or relieve your headaches?

What other family members have headaches? _____

Have you seen other doctors for your headaches? If yes, list whom.

What treatments were given to you? (Biofeedback, acupuncture etc.)

What tests have been done? (CAT scans, MRI, X-ray, etc.)

Do you have any allergies? _____

Have you ever had a seizure or convulsion? _____

How have your headaches affected your daily activities and lifestyle?

What do you think causes your headaches?

The above information is complete and factual: _____ (Patient/Parent/Guardian signature) _____ (Date)

The above information has been reviewed by: _____ (Physician's signature) _____ (Date)

◇ Please bring your completed form with you to your initial appointment ◇