DATE: _____

ABINGTON NEUROLOGICAL ASSOCIATES

(215) 957-9250

Name _____ Birth date _____ Age: _____
(Month/Day/Year)

Address _____ Birthplace _____

_____ Zip code _____

Phone (Home) _____ (Work) _____

(Cell) _____ (Other) _____

Marital Status: ☐ M ☐ S ☐ W ☐ D Religion _____ Race_____

Handedness: ☐ Right Handed ☐ Left Handed Height: _____ Weight: _____

Referred by: ☐ Primary care physician ☐ Neurologist ☐ Family member ☐ Friend
☐ Other _____ Name: _____

Family Physician: _____ Phone: _____

Address: _____

Pharmacy name: _____ Phone: _____

Address: _____

HEADACHE HISTORY:

Do you have <u>more than one headache type</u>? ☐ Yes ☐ No

If yes, please describe each headache type separately as noted by Headache #1, #2, etc.

<u>If one headache type, then fill in information for Headache #1 only and skip Headache #2 section</u> (pages 5-7), and continue to complete questionnaire, starting on page 8.

HEADACHE #1:

Are you ever HEADACHE FREE? ☐ Yes ☐ No

If so, when? ☐ Pregnancy ☐ Vacation ☐ Weekends ☐ Random ☐ Other _____

Onset of First Headache: Headaches started when you were _____ years old.

Precipitating event: (what provoked your first headache?):

☐ None known ☐ Menarche ☐ Pregnancy ☐ Injury _____

☐ Other: _____

Premonitory Symptoms (Do you experience any of these symptoms **<u>before</u>** the headache)**:**

☐ Heightened feeling of wellness	☐ Dizziness	☐ Increased appetitie
☐ Hyperactive	☐ Sensitive to light	☐ Decreased appetite
☐ Extremely talkative	☐ Sensitive to sounds	☐ Feeling cold
☐ Depressed feeling	☐ Sensitive to odors	☐ Diarrhea
☐ Irritable	☐ Difficulty with speech	☐ Constipation
☐ Feeling Sluggish	☐ Excessive yawning	☐ Extreme thirst
☐ Drowsy	☐ Neck Stiffness	☐ Increased Urination
☐ Restless	☐ Food Cravings	☐ Fluid retention
☐ Difficulty concentrating	☐ Weakness	☐ Other: _____

NAME: _____ DATE: _____

Aura (Visual) (Do you have these symptoms **before** your headache begins?):

☐ Blurry vision ☐ Loss of vision in one eye ☐ Tunnel Vision
☐ Flashing lights ☐ Loss of vision on one side ☐ Double vision
☐ Zig zag lines ☐ Total blindness ☐ Other (describe): _____

Do the symptoms spread? ☐ Yes- spreads slowly ☐ No- begins all at once

The visual symptoms start:
☐ before the headache pain ☐ during the headache pain (same time) ☐ both before and during
How long do the visual symptoms last? _____
How much time lapses between the visual symptoms and the headache? _____
Do you have visual auras without headache pain? ☐ Yes ☐ No

Aura (Sensory)

☐ Numbness/tingling- Right ☐ Unsteadiness ☐ Weakness- Right ☐ Speech difficulty
☐ Numbness/tingling- Left ☐ Room spinning ☐ Weakness- Left ☐ Unable to speak
☐ Numbness/tingling- Both ☐ Light headedness ☐ General Weakness ☐ Other:_____

The sensory symptoms start:
☐ before the headache pain ☐ during the headache pain (same time) ☐ both before and during
How long do the sensory symptoms last? _____
How much time lapses between the visual symptoms and the headache? _____
Do you have sensory auras without headache pain? ☐ Yes ☐ No

On average, how quickly do your headaches escalate to their most severe intensity?
☐ Within seconds ☐ Within 5 minutes ☐ Within hours ☐ Within days

Headache Character (check of all that apply):

☐ Throbbing/Pulsating ☐ Pressure ☐ Achy ☐ Dull
☐ Stabbing ☐ Shooting ☐ Burning ☐ Tight
☐ Other: _____

Location:

Sidedness:
☐ Right-sided ☐ Both sides
☐ Left-sided ☐ Varies

Change sides:
☐ Between attacks ☐ Both between and during
☐ During attacks ☐ Only one sided

☐ Front of head ☐ Temples ☐ Side of head ☐ Back of head ☐ Around head
☐ Ear ☐ Eye ☐ Neck ☐ Jaw ☐ Other:_____

NAME: _____ DATE: _____

Associated Symptoms during headache:

Sensitive to:
- ☐ Light
- ☐ Sound
- ☐ Odors

☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Increased appetite
☐ Decreased appetite
☐ Sore/stiff neck
☐ Lightheaded
☐ Anxiety
☐ Irritability
☐ Confusion
☐ Memory Issues
☐ Insomnia
☐ Blurred vision
☐ Ringing in the ears
☐ Hearing pulsations in the ears
☐ Room spinning
☐ Feeling as if you are swaying on a boat
☐ Numbness (where?): _____
☐ Weakness (where?): _____
☐ Increased urination
☐ Eye-tearing (Right Left Both)
☐ Nose congestion (Right Left Both)
☐ Eye-redness (Right Left Both)
☐ Drooping eyelid (Right Left Both)
☐ Change in pupil (Larger Smaller)
☐ Other (describe): _____

Activity that worsens headache:

☐ None ☐ Movement in general ☐ Walking
☐ Climbing ☐ Exercise ☐ Other: _____

Do the headaches awaken you from sleep? ☐ Yes ☐ No
Do you awaken with the headache in the AM? ☐ Yes ☐ No
Do you awaken with headache after naps? ☐ Yes ☐ No ☐ Not applicable

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Provoking Factors: things that bring on a headache

Food/beverage: Fasting _____ Chocolate_____ Caffeine _____Nitrates _____MSG_____
Alcohol beverages_____ **Wine**: Red _____ White _____ Other:_____

Physical exertion: Coughing _____ Talking_____ Chewing _____ Exercise_____
Sexual intercourse_____

Hormonal: Menses: Before_____ During_____ After_____
Pregnancy_____ Menopause_____

Stress: Work_____ Home_____ Family_____ Spouse_____ Other_____

Environmental: Temperature changes _____ Barometric Pressure changes _____
Allergies_____ Altitude _____ Sunlight_____ Other_____

Sleep: Lack of sleep_____ Too much sleep_____ Change in wake/sleep_____

Other Triggers: _____

Relieving Factors (List)

☐ Lying down ☐ Hot compress ☐ Massage
☐ Dark quiet room ☐ Cold compress ☐ Pregnancy
☐ Keeping active/ pacing ☐ Standing ☐ Other _____

NAME: _____ DATE: _____

HEADACHE FREQUENCY (enter the **number** of attacks):
__ #/day __ #/week __ #/month __ #/year ☐ Continuous

If you have continuous headache, how frequent do your headaches become more severe and/or debilitating?
__ #/day __ #/week __ #/month __ #/year ☐ Continuous ☐ Not applicable

When are they more frequent?
☐ Spring ☐ Summer ☐ Fall ☐ Winter
☐ Weekends ☐ Weekdays ☐ Vacation ☐ Not applicable

HEADACHE SEVERITY
(How bad is the pain on a scale from 0-10: where 0 is no pain and 10 is the worst):
Range of severity of pain for this headache type: Lowest _____ Highest _____
Average Severity of pain for this headache type: _____
Worse with menses? ☐ Yes ☐ No

Headache disability during or after an attack (Decrease in function):
☐ Normal activity ☐ Slight decrease in function ☐ Moderate decrease in function
☐ Severe decrease in function ☐ Confined to bed

HEADACHE DURATION (How long do they last? Enter the **amount** of time):
With medication: __ Minutes __ Hours __ Days % of the time they recur within 24hrs ___
Without medication: __ Minutes __ Hours __ Days % of the time they recur within 24hrs ___

*****If you only have one headache type, go to page 8*****

HEADACHE #2: ***(if you have only one headache type, skip this section and go to page 8)***

NAME: _____ DATE: _____

Are you ever HEADACHE FREE? ☐ Yes ☐ No
If so, when? ☐ Pregnancy ☐ Vacation ☐ Weekends ☐ Random ☐ Other _____

Onset of First Headache: Headaches started when you were _____ years old.

Precipitating event: (what provoked your first headache?):
☐ None known ☐ Menarche ☐ Pregnancy ☐ Injury _____
☐ Other: _____

Premonitory Symptoms (Do you experience any of these symptoms **before** the headache)**:**

☐ Heightened feeling of wellness	☐ Dizziness	☐ Increased appetitie
☐ Hyperactive	☐ Sensitive to light	☐ Decreased appetite
☐ Extremely talkative	☐ Sensitive to sounds	☐ Feeling cold
☐ Depressed feeling	☐ Sensitive to odors	☐ Diarrhea
☐ Irritable	☐ Difficulty with speech	☐ Constipation
☐ Feeling Sluggish	☐ Excessive yawning	☐ Extreme thirst
☐ Drowsy	☐ Neck Stiffness	☐ Increased Urination
☐ Restless	☐ Food Cravings	☐ Fluid retention
☐ Difficulty concentrating	☐ Weakness	☐ Other: _____

Aura (Visual) (Do you have these symptoms before your headache begins?):

☐ Blurry vision	☐ Loss of vision in one eye	☐ Tunnel Vision
☐ Flashing lights	☐ Loss of vision on one side	☐ Double vision
☐ Zig zag lines	☐ Total blindness	☐ Other (describe): _____

Do the symptoms spread? ☐ Yes- spreads slowly ☐ No- begins all at once

The visual symptoms start:
☐ before the headache pain ☐ during the headache pain (same time) ☐ both before and during
How long do the visual symptoms last? _____
How much time lapses between the visual symptoms and the headache? _____
Do you have visual auras without headache pain? ☐ Yes ☐ No

Aura (Sensory)

☐ Numbness/tingling- Right	☐ Unsteadiness	☐ Weakness- Right	☐ Speech difficulty
☐ Numbness/tingling- Left	☐ Room spinning	☐ Weakness- Left	☐ Unable to speak
☐ Numbness/tingling- Both	☐ Light headedness	☐ General Weakness	☐ Other:_____

The sensory symptoms start:
☐ before the headache pain ☐ during the headache pain (same time) ☐ both before and during
How long do the sensory symptoms last? _____
How much time lapses between the visual symptoms and the headache? _____
Do you have sensory auras without headache pain? ☐ Yes ☐ No

On average, how quickly do your headaches escalate to their most severe intensity?

NAME: _____ DATE: _____

☐ Within seconds ☐ Within 5 minutes ☐ Within hours ☐ Within days

---

Headache Character (check of all that apply):

☐ Throbbing/Pulsating ☐ Pressure ☐ Achy ☐ Dull
☐ Stabbing ☐ Shooting ☐ Burning ☐ Tight
☐ Other: _____

Location:

Sidedness:
☐ Right-sided
☐ Left-sided
☐ Both sides
☐ Varies

Change sides:
☐ Between attacks
☐ During attacks
☐ Both between and during
☐ Only one sided

☐ Front of head ☐ Temples ☐ Side of head ☐ Back of head ☐ Around head
☐ Ear ☐ Eye ☐ Neck ☐ Jaw ☐ Other:_____

Associated Symptoms during headache:

Sensitive to:
- ☐ Light
- ☐ Sound
- ☐ Odors

☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Increased appetite
☐ Decreased appetite
☐ Sore/stiff neck

☐ Lightheaded
☐ Anxiety
☐ Irritability
☐ Confusion
☐ Memory Issues
☐ Insomnia
☐ Blurred vision
☐ Ringing in the ears
☐ Hearing pulsations in the ears
☐ Room spinning

☐ Feeling as if you are swaying on a boat
☐ Numbness (where?): _____
☐ Weakness (where?): _____
☐ Increased urination
☐ Eye-tearing (Right Left Both)
☐ Nose congestion (Right Left Both)
☐ Eye-redness (Right Left Both)
☐ Drooping eyelid (Right Left Both)
☐ Change in pupil (Larger Smaller)
☐ Other (describe): _____

Activity that worsens headache:

☐ None ☐ Movement in general ☐ Walking
☐ Climbing ☐ Exercise ☐ Other: _____

Do the headaches awaken you from sleep? ☐ Yes ☐ No
Do you awaken with the headache in the AM? ☐ Yes ☐ No
Do you awaken with headache after naps? ☐ Yes ☐ No ☐ Not applicable

Provoking Factors: things that bring on a headache

Food/beverage: Fasting _____ Chocolate_____ Caffeine _____Nitrates _____MSG_____
Alcohol beverages_____ **Wine**: Red _____ White _____ Other:_____

Physical exertion: Coughing _____ Talking_____ Chewing _____ Exercise_____
Sexual intercourse_____

Hormonal: Menses: Before_____ During_____ After_____

NAME: _____ DATE: _____

	Pregnancy_____ Menopause_____
Stress:	Work_____ Home_____ Family_____ Spouse_____ Other_____
Environmental:	Temperature changes _____ Barometric Pressure changes _____
	Allergies_____ Altitude _____ Sunlight_____ Other_____
Sleep:	Lack of sleep_____ Too much sleep_____ Change in wake/sleep_____
Other Triggers:	_____

Relieving Factors (List)

☐ Lying down	☐ Hot compress	☐ Massage
☐ Dark quiet room	☐ Cold compress	☐ Pregnancy
☐ Keeping active/ pacing	☐ Standing	☐ Other _____

HEADACHE FREQUENCY: (the **number** of attacks):

__ #/day __ #/week __ #/month __ #/year ☐ Continuous

If you have continuous headache, how frequent do your headaches become more severe and/or debilitating?

__ #/day __ #/week __ #/month __ #/year ☐ Continuous ☐ Not applicable

When are they more frequent? (Check all that apply)

☐ Spring ☐ Summer ☐ Fall ☐ Winter

☐ Weekends ☐ Weekdays ☐ Vacation ☐ Not applicable

SEVERITY (How bad is the pain on a scale from 0-10: where 0 is no pain and 10 is the worst):

Range of severity of pain for this headache type: Lowest _____ Highest _____

Average Severity of pain for this headache type: _____

Worse with menses? ☐ Yes ☐ No

Headache disability during or after an attack (Decrease in function):

☐ Normal activity ☐ Slight decrease in function ☐ Moderate decrease in function

☐ Severe decrease in function ☐ Confined to bed

HEADACHE DURATION (How long do they last? Enter the **amount** of time):

With medication: __ Minutes __ Hours __ Days % of the time they recur within 24hrs ___

Without medication: __ Minutes __ Hours __ Days % of the time they recur within 24hrs ___

NAME: _____ DATE: _____

Previous Treatments and Testing:

Write Yes, or care provider names if known, for all treatments tried:

Primary Care Provider:	_____	Psychiatrist/Psychologist:	_____
Neurologist:	_____	Biofeedback/Relaxation:	_____
ENT/Otolaryngologist:	_____	Physical Therapy:	_____
Dentist/Dental:	_____	Massage:	_____
Chiropractor:	_____	Acupuncture/Acupressure:	_____
Ophthalmologist:	_____	Herbal/Homeopathic:	_____

QUALITY OF LIFE REVIEW:

SLEEP: I get _____ hours of sleep per night.

Check all that apply:

- ☐ I have no trouble falling & staying asleep
- ☐ I have trouble falling asleep
- ☐ I have trouble staying asleep
- ☐ I wake up for no apparent reason
- ☐ I snore
- ☐ I stop breathing in my sleep
- ☐ I have sleep apnea
- ☐ I am excessively sleepy during the day
- ☐ My legs jerk while sleeping
- ☐ I have restless legs
- ☐ My headache awakens me
- ☐ I wake up with headaches in the morning
- ☐ I sleep too much

My sexual function is: (check all that apply)

- ☐ Normal
- ☐ Decreased libido
- ☐ Increased libido
- ☐ No orgasms
- ☐ Problems with erections
- ☐ Other: _____

Headache's effect on ability to function: (Do your headaches affect?)
Record # of days missed per month of work/school and or social and family activities

- ☐ Work productivity _____ #days/month missed
- ☐ School productivity _____ # days/month missed
- ☐ Social/family activities _____ # days/missed

NAME: _____ DATE: _____

FAILED HEADACHE MEDICATIONS:

PART 1. Please circle any drug used daily for headache prevention & fill in the additional information where possible, including:

a) **highest dose used (note if the medicine was divided through the day)**
b) **length of time medication was used in weeks or months (Time)**
c) **please write "NE" if the medicine was not effective (NE), or if you had side effects (SE), write what problems you had in the appropriate space below**

Medication	Dose	Time	NE or SE
Beta Blocker			
timolol			
Inderal (propanolol)			
Toprol (metoprolol)			
Corgard (nadolol)			
Tenormin (atenolol)			
ACE Inhibitor			
lisinopril			
ARB			
Candesartan			
Ca Channel Blocker			
Calan (verapamil)			
Cardizem (diltiazem)			
Norvasc (amlodipine)			
Plendil (felodipine)			
Procardia (nifedipine)			
TCA			
Pamelor (Nortriptyline)			
Elavil (Amytriptyline)			
Vivactil (Protryptaline)			
Tofranil (imipramine)			
Norpramin (desipramine)			
Sinequan (doxepin)			
Muscle Relaxants			
Flexeril			
Parafon Forte (Chlorzoxazone)			
Skelaxin			
Zanaflex			

Medication	Dose	Time	NE or SE
SNRI			
Effexor XR (Venlafaxine)			
Cymbalta (duloxetine)			
Savella (milnacipran)			
SSRI			
Buspar (buspirone)			
Prozac (fluoxetine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (excitalopram)			
Luvox (fluvoxamine)			
Zoloft (sertraline)			
MAOI			
Nardil			
Parnate (Tranylcypromine)			
MISC			
Serzone (Nefazodone)			
Remeron (mirtazapine)			
Desyrel (Trazodone)			
NDRI			
Wellbutrin, Zyban (buproprion)			
Benzodiazepines			
Ativan			
Klonopin (clonazepam)			
Librium			
Limbitrol			
Valium (diazepam)			
Xanax (alprazolam)			

NAME: _____ DATE: _____

Medication	Dose	Time	NE or SE
(tizanadine)			
baclofen			
Soma (carisoprodol)			
NSAIDS			
Relafen (nabumetone)			
Arthrotec (diclofenac & misoprostol)			
Voltaren, Cataflam (diclofenac)			
Indocin (indomethacin)			
Feldene (piroxicam)			
Mobic (meloxicam)			
Clinoril (sulindac)			
Neuroleptics			
Abilify (Aripiprazole)			
Seroquel (quetiapine)			
Risperdal (risperdone)			
Navane (thiothixene)			
Zyprexa (olanzapine)			
Haldol			
Triavil (phenothiazine)			
Thorazine (chlorpromazine)			
PROCEDURES:			
Botox			
cGRP medications			

Medication	Dose	Time	NE or SE
AED			
Topamax (topiramate)			
Zonegran (zonisamide)			
Neurontin (gabapentin)			
Lamictal (lamotrigine)			
Lyrica (pregabalin)			
Depakote (valproic Acid)			
Gabitril (tiagabine)			
Keppra (levitiracetam)			
Dilantin (phenytoin)			
Trileptal (oxcarbamazepine)			
Tegretol (carbamazepine)			
Banzel (rufinamide)			
Vimpat (lacosamide)			
Miscellaneous			
Petadolex			
Melatonin			
Vitamin B2 (Riboflavin)			
Magnesium			
Coenzyme Q10			
Feverfew			
Methergine			
Sansert (methysergide)			
Migrelief (Mg, B12, feverfew)			
Periactin (Cyproheptadine)			
Lithium			
Catapres (clonidine)			
Diamox			

NAME: _____ DATE: _____

PART 2. Please circle any medicines that you have taken for your <u>headache rescue/abortive</u> & fill in the additional information where possible, including:

a) **<u>highest</u> dose used**
b) **please write "NE" if the medicine was not effective (NE), or if you had side effects (SE), write what problems you had in the appropriate space below**

Medication	Dose	NE or SE
Anti-inflammatory		
Aleve, Anaprox, Naprelan (naprosyn)		
Arthrotec (diclofenac, misoprostol)		
Advil, Motrin (ibuprofen)		
Aspirin		
Celebrex (celecoxib)		
Clinoril (sulindac)		
Daypro (oxaprozin)		
Excedrin		
Feldene		
Indocin (indomethacin)		
Orudis, Oruvail (ketoprofen)		
Cambia		
Relafen (nabumetone)		
Toradol (ketorolac)		
Voltaren (diclofenac)		
Vioxx		
Triptans/Ergots		
Imitrex tabs		
Imitrex nasal spray		
Imitrex injections		
Maxalt		
Maxalt MLT		
Zomig		
Zomig nasal		
Relpax		
Axert		
Amerge		
Frova		
DHE		
Migranal		
Wigraine (ergotamine & caffeine)		
Procedures		
Occipital Nerve blocks		
Trigeminal nerve blocks		
Trigger point injections		
Sphenopalatine Ganglion blocks		
Facet blocks		

Medication	Dose	NE or SE
Neuroleptics		
Compazine (prochlorperazine)		
Phenergan (promethazine)		
Reglan (metoclopramide)		
Zyprexa (Olanzapine)		
Thorazine (chlorpromazine)		
Haldol		
Droperidol		
Navane (thiothixene)		
Muscle relaxants		
Flexeril		
Amrix		
Norflex (Orphenadrine)		
Norgesic (Norflex, Aspirin, caffeine)		
Parafon Forte(Chlorzoxazone)		
Zanaflex		
Skelaxin		
Robaxin (methocarbamol)		
Soma (carisoprodol)		
baclofen		
Benzodiazepines		
Klonopin (clonazepam)		
Valium (diazepam)		
Xanax (alprazolam)		
Steroids		
Decadron (dexamethasone)		
Medrol Dose Pak		
Prednisone (prednisolone)		
Miscellaneous		
Ultram (tramadol)		
Tylenol		
Midrin		
Tigan (Trimethobenzamide)		
Zofran		
Benadryl (diphenhydramine)		
Vistaril (hydroxyzine)		
Antivert (meclizine)		
Combinations		
Bellergal (belladonna, ergotamine, & phenobarbital)		
Cafergot (ergotamine & caffeine)		

NAME: _____ DATE: _____

Medication	Dose	NE or SE
Opiates		
Codeine (methylmorphine)		
Tylenol #3 (codeine & acetaminophen)		
Darvon (Dextropropoxyphene)		
Darvocet (propoxyphene & acetaminophen)		
Lortab (hydrocodone)		
Vicodin (hydrocodone, acetaminophen)		
Vicoprofen (hydrocodone, ibuprofen)		
MSIR (morphine)		
MS Contin (morphine, extended release)		
Oxy IR (Oxycodone)		
OxyContin (oxycodone, extended release)		
Percocet (oxycodone &acetaminophen)		
Percodan (oxycodone & ASA)		
Dilaudid (hydromorphone)		
Duragesic patch (fentanyl)		
Demerol (Meperidine)		
Stadol (butorphanol)		
Talwin (pentazocine)		
Methadone		
Nubain (Nalbuphine)		

Medication	Dose	NE or SE
Barbiturates		
Fioricet (butalbitol, acetaminophen, caffeine)		
Fioricet with codeine		
Fiorinal (butalbitol, aspirin, caffeine)		
Fiorinal with codeine		
Phrenilin (butalbital & acetaminophen)		
Nembutal (pentobarbital)		
Miscellaneous		
Marinol		
Marijuana		
Vagal nerve stimulator		
Transcranial magnetic stimulator		

You can use this space to describe anything you feel is important that was not covered in the questionnaire.

_____

_____

_____

_____

The above information is true and correct to the best of my belief.

Signed: _____ Date: _____