



## HEALTH HISTORY QUESTIONNAIRE/HEADACHE PATIENTS

Name ( <i>Last, First, M.I.</i> )	<input type="checkbox"/> M <input type="checkbox"/> F	Height:	DOB:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Primary Care Physician: _____		Referring Clinician (if different): _____	

PERSONAL HEALTH HISTORY
<b>Please list any significant medical conditions you have had, past or present:</b>

Surgeries (only if related to your headaches)		
Year	Reason	Hospital

Other Hospitalizations		
Year	Reason	Hospital

\_\_\_\_\_  
 Last Name, First Name

### HEALTH HABITS AND PERSONAL SAFETY

<b>Exercise</b>	<input type="checkbox"/> Sedentary (no exercise)		
	<input type="checkbox"/> Mild exercise (i.e. climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e. work or recreation 4x/week for 30 min)		
<b>Diet</b>	Are you on a special diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you eat a healthy diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea
	<input type="checkbox"/> Soda		
<b>Alcohol</b>	Do you drink alcohol?		
	If yes, what kind?		
	How many drinks per week?		
<b>Tobacco</b>	Do you use or have you ever used tobacco?		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="checkbox"/> Cigarettes – pk/day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Cigars – #/day	
<b>Drugs</b>	<input type="checkbox"/> Year quit		
	Do you currently use recreational or street drugs?		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you ever given yourself street drugs with a needle?		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Sex</b>	Are you sexually active?		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If not trying for a pregnancy, list contraceptive or barrier method used:		

### FAMILY HEALTH HISTORY

Did/do they have diabetes, high blood pressure, cancer, high cholesterol, heart disease, thyroid disease, asthma, migraines, Alzheimer's, drug or alcohol abuse, other (list)				
	Age	Age	Age	Significant Health Problems
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F
<b>Brothers/ Sisters</b>	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>	
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>	
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>	
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>	

\_\_\_\_\_  
*Last Name, First Name*

**MEDICATIONS**

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

Name the Drug	Strength	Frequency Taken

**Allergies to Medications**

Name the Drug	Reaction You Had

\_\_\_\_\_  
*Last Name, First Name*

√ **CHECK to the left of symptom if you have now or in the recent past:**

<b>Constitutional</b>	<b>Gastrointestinal</b>	<b>Cardiovascular</b>
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Swallowing problem	<input type="checkbox"/> Chest pain or pressure
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Fevers	<input type="checkbox"/> Bloating	<input type="checkbox"/> Wake up breathless
<input type="checkbox"/> Significant Weight change	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Ankle swelling
<b>Head Neck neuro</b>	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Leg cramping
<input type="checkbox"/> Vision changes	<input type="checkbox"/> Nausea	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Cold feet or hands
<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Passing out
<input type="checkbox"/> Dizziness or vertigo	<input type="checkbox"/> Constipation	<b>Musculoskeletal</b>
<b>Ear, Nose, Throat</b>	<input type="checkbox"/> Bowels irregular	<input type="checkbox"/> Joint stiffness
<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Black stool	<input type="checkbox"/> Joint swelling
<input type="checkbox"/> Sinus – Nose bleeds	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Muscle aches
<input type="checkbox"/> Oral lesions	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Weakness
<input type="checkbox"/> Neck or jaw pain	<b>Genitourinary</b>	<input type="checkbox"/> Change in moles
<input type="checkbox"/> Lumps in Neck	<input type="checkbox"/> Menstrual trouble	<input type="checkbox"/> Rashes-Bump-Bruises
<b>Respiratory</b>	<input type="checkbox"/> Menopause	<input type="checkbox"/> Numbness
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Tingling
<input type="checkbox"/> Cough	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Low back pain
<input type="checkbox"/> Sputum	<input type="checkbox"/> Urge to urinate	<input type="checkbox"/> Blood clots-Phlebitis
<input type="checkbox"/> Coughed up blood	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Deformity/Amputation
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Blood in urine	
<input type="checkbox"/> Snoring	<input type="checkbox"/> Discharge	
<input type="checkbox"/> Breathless with walking	<input type="checkbox"/> Awakening to urinate	
<input type="checkbox"/> Breathless when flat in bed	<input type="checkbox"/> Change in stream	
	<input type="checkbox"/> Lumps in testicles	

**Please explain/describe and symptoms that were checked above:**


\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date