CHRISTINE HARTER, MD
Internal Medicine & Headache Care

2915 W. Rose Garden Lane #102,
Phoenix, AZ 85027
Phone (623) 748-8300
Fax (623) 748-8314
www.hartercare.com

HEALTH HISTORY QUESTIONNAIRE/HEADACHE PATIENTS

Name *(Last, First, M.I.)* ☐ M ☐ F	Height:	DOB:
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Primary Care Physician: ______________________	Referring Clinician (if different): ______________________	

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

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

____
Last Name, First Name

HEALTH HABITS AND PERSONAL SAFETY

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

FAMILY HEALTH HISTORY

	Age	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	Significant Health Problems
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Brothers/ Sisters	☐ M ☐ F		Grandmother *Maternal*		
	☐ M ☐ F		Grandfather *Maternal*		
	☐ M ☐ F		Grandmother *Paternal*		
	☐ M ☐ F		Grandfather *Paternal*		

____
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:

Constitutional

- ☐ Insomnia
- ☐ Loss of appetite
- ☐ Fevers
- ☐ Significant Weight change

Head Neck neuro

- ☐ Vision changes
- ☐ Headaches
- ☐ Memory Loss
- ☐ Dizziness or vertigo

Ear, Nose, Throat

- ☐ Ringing in the ears
- ☐ Hoarseness
- ☐ Sinus – Nose bleeds
- ☐ Oral lesions
- ☐ Neck or jaw pain
- ☐ Lumps in Neck

Respiratory

- ☐ Shortness of breath
- ☐ Cough
- ☐ Sputum
- ☐ Coughed up blood
- ☐ Wheezing
- ☐ Snoring
- ☐ Breathless with walking
- ☐ Breathless when flat in bed

Gastrointestinal

- ☐ Swallowing problem
- ☐ Heartburn
- ☐ Bloating
- ☐ Abdominal pain
- ☐ Ulcers
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bowels irregular
- ☐ Blood in stool
- ☐ Black stool
- ☐ Jaundice
- ☐ Hemorrhoids

Genitourinary

- ☐ Menstrual trouble
- ☐ Menopause
- ☐ Incontinence
- ☐ Frequent urination
- ☐ Urge to urinate
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Discharge
- ☐ Awaking to urinate
- ☐ Change in stream
- ☐ Lumps in testicles

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Palpitations
- ☐ Wake up breathless
- ☐ Ankle swelling
- ☐ Leg cramping
- ☐ Varicose veins
- ☐ Cold feet or hands
- ☐ Passing out

Musculoskeletal

- ☐ Joint stiffness
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle aches
- ☐ Weakness
- ☐ Change in moles
- ☐ Rashes-Bump-Bruises
- ☐ Numbness
- ☐ Tingling
- ☐ Low back pain
- ☐ Blood clots-Phlebitis
- ☐ Deformity/Amputation

ALLERGIES		
Do you experience any of these symptoms more than twice per year: Cough, cold, congestion, difficulty breathing, headaches, wheezing, runny nose, sore throat, itchy/irritated eyes, unexplained fatigue, sinus pain, ear pain, skin irritation?	☐ Yes	☐ No
Have you ever been diagnosed with asthma or bronchitis?	☐ Yes	☐ No
Do you experience symptoms of allergies?	☐ Yes	☐ No
We offer allergy testing and no-shot allergy treatment at this office. Would you like to find out more about this?	☐ Yes	☐ No

Patient Signature　　　　　　　　　　Date

Christine Harter M.D.,PC

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.: XXXXXXXXXXXXXXXXXXXXXXXXXX	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ AHCCCS	❑ AETNA	❑ HUMANA	❑ UHC

❑ BCBS	❑ STATE COMP	❑ CIGNA	❑ UNINSURED	❑ Other

Subscriber's name:	Subscriber's S.S. no.: XXXXXXXXXXXXXXXXXXX	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Pharmacy Name:	**Address:**	**Phone:**	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Christine Harter M.D., PC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Referral Policy

Christine Harter M.D., PC

Our office would like you as our patient to take time and read the following information about our referral process.

A referral, also called pre-authorization, is the approval our office must obtain before admitting you to the hospital or providing or referring you for other types of specialty services. Without this approval your medical care may not be covered and you could be responsible for 100% of the bill.

Dr. Harter authorizes referrals she believes are appropriate given your health condition. Dr. Harter requires an office visit prior to authorizing a referral and can treat most conditions in our office.

You as the patient have the following responsibilities:

1. Verify the specialist is participating on your plan.
2. Schedule your appointment and provide the specialty office with your personal and insurance information.
3. Inform our office of the specialist name, date of appointment, and phone and fax number.

****WE REQUIRE SEVEN (7) DAYS ADVANCE NOTICE****

URGENT REFERRALS WILL BE EXPEDITED AT THE PHYSICIAN'S DISCRETION

Our office will:

1. Obtain and complete all referral forms.
2. Contact your insurance company to obtain authorization.
3. Fax to the specialty location your referral and pertinent medical information.
4. You will be contacted when the process is complete.

I have read and understand the practice's referral policy and I agree to be bound by its terms. I also understand and agree such terms may be amended by the practice from time to time.

______________________________________ ______________________________________

Signature of Patient (or responsible party, if minor) DATE

____

Printed Name of Patient

Effective Date of Notice: April 14, 2003

Christine Harter, M.D., P.C.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Christine Harter, M.D., P.C. is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office, a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

1. **Treatment:** We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. **Payment:** We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. **Health Care Operations:** We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit the office.
4. **Appointment Reminders:** We may use and disclose your information to remind you of appointments. We may also mail you a reminder for follow-up visits.
5. **Treatment Options:** We may use your health information to inform you of treatment options or other health-related services we offer that may be of interest to you.
6. **Business Associates:** We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hours telephone answering, billing, or quality assurance. Our Business Associates agree to protect the privacy of your information,

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases.
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect, or domestic violence.
- To health oversight agencies.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes. To a medical examiner, coroner, or funeral director.
- For the facilitation of organ, eye, or tissue donation if you are an organ donor.
- For research purposes under strictly limited circumstances,
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.

Form 1 64.520-A

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Practice will provide you with an authorization form to complete and return to the address listed on it.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. **Restrictions on Use and Disclosure:** You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure ofyour health information to only certain individuals, or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.

2. **Confidential Communications:** You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.

3. **Access:** You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denia1.

4. **Record Amendment:** You have the right to request amendments to your health records created by and for this Practice if you feel they are incorrect or incomplete. We may accept or deny your request. Ifwe deny your request, you have the right to provide a statement of disagreement.

5. **Accounting of Disclosures:** You have the right to receive an accounting of disclosures. This means you may request a list of cel1ain disclosures Practice has made of your records. Upon your request, we will provide this information to you one time fi'ee during each twelve (12) month period. There may be a fee for additional copies.

6. **Copy of Notice:** You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have questions about this notice, please contact Practice's Privacy Officer at Christine Harter, M.D., P.C.; or (623) 748-8300. If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

I have received a copy of this office's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

________________________________	________________________________
Printed Patient Name	Name/Relationship if Signed by Individual Other than Patient
________________________________	________________________________
Signature	Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

____ Individual Refused to Sign   _____ Communication Barrier   _____ Care Provided was Emergent

_____ Other: ____   ____
Employee Name   Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____________________
Address: ____________________
____
____

Other Name: ____________________
Birth date: ____________________
Soc. Sec. No.: Last 4 Digits Only ________

I hereby authorize:

____

to release a copy of the following information:

____

To: Christine Harter, M.D., P.C.
2915 W. Rose Garden Lane, Suite 102
Phoenix, AZ 85027
Phone: (623) 748-8300 Fax: (623) 748-8314

- ☐ For continuity of care
- ☐ Other

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

I ☐ **do** ☐ **do not** authorize the release of this type of information.

I understand:

- I may revoke this authorization except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization.

______________________________ ____________________
Patient or Personal Representative's Signature Date

____
Description of Representative's Authority to Act for Patient

- This authorization will expire in 90 days.

Form 164.508-B

Medication History

Patient Name:_________________________
DOB: _________________________________

Please check those medications that you have <u>tried in the past</u>.

Beta Blockers

- —— Propranolol (Inderal)
- —— Atenolol (tenormin)
- —— Nadolol (Corgard)
- —— Metoprolol (Lopressor)
- —— Other

Calcium Blockers

- —— Verapamil (Calan, Veralan)
- —— Nicardipine (Cardene)
- —— Other

Tricyclic/Tetracyclic Antidepressants

- —— Amitriptyline (Elavil)
- —— Nortriptyline (Pamelor)
- —— Doxepin
- —— Desaryl (trazadone)
- —— Other

Anticonvulsants

- —— Valporic acid (Depakote)
- —— Gabapentin (neurontin)
- —— Lamotrigene (Lamictal)
- —— Topiramate (Topamax)
- —— Tiagabine (Gabitril)
- —— Zonagran
- —— Trileptan
- —— Keppra
- —— Pregabalin (Lyrica)

SSRIs

- —— Zoloft
- —— Paxil
- —— Serzone
- —— Celexa
- —— Lexapro
- —— Prozac

SRI/Dopamine Inhibitors

- —— Wellbutrin
- —— Effexor

5 HT Antagonists

- —— Methesergide (sansert)
- —— Methylergonovine (Methergine)
- —— Ciproheptadine (Periactin)
- —— Phenalzine (Nardil)

Muscle Relaxers

- —— Liorisal (Baclofen)
- —— Cyclobenzaprine (Flexeril)
- —— Tizanidine (Zanaflex)
- —— Botulinum toxin (Botox)

Leukotriene Antagonists

- —— Montelkaust (Singulair)
- —— Other

Long -acting Narcotics

- —— Methadone
- —— Oxycontin
- —— MS Contin
- —— Duragesic
- —— Avinza

Vitamins/Minerals

- —— Vitamin B2 (Riboflavin)
- —— Magnesium

Migraine Medicines

- —— Imitrex (Sumatriptan)Pill
- —— Imitrex Nasal Spray
- —— Imitrex Injection
- —— Axert
- —— Relpax
- —— Maxalt
- —— Zomig
- —— Zomig Nasal Spray
- —— Amerge

Migraine Medicines (contd.)

- —— Cafergot
- —— DHE 45
- —— Migranal Nasal Spray
- —— Frova

Pain medicines

- —— Codeine
- —— Ultram or Ultracet (tramadol)
- —— Hydrocodone (Vicodin/Lortab)
- —— Stadol Nasal Spray
- —— Oxycodone (Percocet/Roxicet/Roxicodone)
- —— Demerol pills or injections
- —— Dilaudid
- —— Other

Anti-Inflammatories

- —— Ibuprofen (Advil/Motrin)
- —— Naproxen (Naprosyn/Aleve)
- —— Ketoprofen (Orudis/Oruvail)
- —— Indocin 25mg Pills
- —— Indocin 25mg Suppository
- —— Celebrex
- —— Bextra
- —— Other

Mixed Analgesics

- —— Excedrin
- —— Bultalbital (Fioricet/Esgie Plus)
- —— Midrin/Duradrin
- —— Other

Antinauseants

- —— Metocloprimide
- —— Promethazine (Phenergan)
- —— Compazine
- —— Zofran
- —— Other

Physical/Other

- —— Lidocaine 4%
- —— Oxygen
- —— Accupuncture
- —— Biofeedback
- —— Steroids

IV Treatments

- —— Magnesium
- —— Toradol
- —— Inapsine
- —— Other

CHRISTINE HARTER, M.D., P.C.

PATIENT REGISTRATION FORM

Welcome to Christine Harter, M.D., P.C. It is our pleasure to provide you with excellent health care in internal medicine and/or headache care.

Please take a few minutes to read the following policies that will help us serve you better, and make your visit more enjoyable.

1. If your address, telephone number, or Insurance Coverage changes, please notify us immediately.

2. Please arrive prior to the time of your appointment. If you are more than 15 minutes late, we may ask you to reschedule so that other patients are seen at their scheduled appointment times.

3. You may be charged $50.00 if you miss an appointment, or do not cancel or reschedule 24-hours prior to your appointment. If you miss two appointments in a 12-month period, you may be DISCHARGED from the practice.

4. If you need a prescription refilled, please contact your pharmacy and they will contact us. Prescriptions will not be refilled after-hours or on weekends.

5. Messages left for Dr. Harter after 3:00 p.m., and on weekends, will not be returned until the next business day.

6. There is a $25.00 charge per page for filling out any forms required by third parties, such as Disability Ins., Life Ins., Car Accidents, etc…

7. There is an administrative fee ranging from $15 - $50.00 if you request a copy of your medical records.

8. There will be a $40.00 fee for all NSF checks. If your account is sent to collections for failure to pay account balance when due, you will be charged a collection fee of $50.00 in addition to the amount you owe on your account.

9. No food or drink, other than water, is to be consumed in the waiting or exam rooms.

10. Minor children must be accompanied by a parent or legal guardian.

Thank you for your understanding, and please acknowledge your acceptance of these policies by signing and dating below.

____ Date: ____________________

Signature

Christine Harter, M.D., P.C.

Christine Harter, M.D.

2915 W. Rose Garden Lane, Suite 102
Phoenix, AZ 85027
Office: 623.748.8300 Fax: 623.748.8314

Patient Name: ____

Guardian Name (if applicable): ______________________________

The following information will assist the physician and staff in contacting you with test results, medical information, and financial, or insurance issues.

Where is the best phone number to reach you between 8:30 a.m. and 5:00 p.m.?____________

If we cannot reach you personally, may we leave a message on?

Yes	No		
☐	☐	Answering machine at home	Home phone: ______________
☐	☐	Voicemail at work	Work phone: ______________
☐	☐	Cell phone voicemail	Cell phone: _______________
☐	☐	______________________ Other person(s) i.e. family member	_________________________

We will not send confidential medical information out through e-mail, since the Internet is not secure, though we will be developing a secure Internet e-mail portal, probably in 2011. To be able to update you on these new services, and to provide a medical newsletter to you no more often than quarterly, we would appreciate your e-mail address:

E-mail address: ____

Date _______________________ Signature__________________________________
Date _______________________ Signature__________________________________
Date _______________________ Signature__________________________________
Date _______________________ Signature__________________________________
Date _______________________ Signature__________________________________
Date _______________________ Signature__________________________________
Date _______________________ Signature__________________________________
Date _______________________ Signature__________________________________

2915 W. Rose Garden Lane #102,
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www.hartercare.com

Headache Questionnaire

Name: ________________________________ **Date:** _________________

1. At what **age** did your headaches **begin**? ______________

2. Does anyone in your family have chronic headaches? List below:

_______________________________________ _______________________________________

_______________________________________ _______________________________________

3. Have you had any history of head trauma? _______________________________________

4. How **often** do you have headaches per week, on average? ___________________________________

5. **Where** are your headaches typically located? _______________________________________

6. What **time of day** do they usually start (approximately), or does it vary a lot? ____________

7. Is there anything that usually **triggers** your headache? Some typical triggers for headache are: (check any that apply to you)

- ☐ Caffeine
- ☐ Menstrual period
- ☐ Sexual intercourse
- ☐ Skipped meal
- ☐ Alcoholic beverages esp. beer and wine
- ☐ Citrus
- ☐ Too little or too much sleep
- ☐ Flashing lights
- ☐ Neck movement
- ☐ Chocolate

List any not listed here: ____

8. Do you have any **symptoms** other than pain with your headache? (check any that apply to you)

- ☐ Nausea
- ☐ Vomiting
- ☐ Sensitivity to Light or Sound
- ☐ Visual symptoms just prior to, or with, your headaches
- ☐ Tingling or Weakness in Arms
- ☐ Tingling or Weakness in Legs
- ☐ Fever

Describe: ____

List any not listed here: ____

There are two kinds of medicine for chronic headaches; **preventative** medicines that are taken on a **daily** basis to either prevent or at least lessen the frequency or severity of the headaches, and medicines that are taken on an **as needed** basis to **sto**p the headache (hopefully) once it has started.

Please list below all daily preventative medicines that you have been on (if any) and whether it worked, and list any side effects of the medication.

Medication	Effect?	Side Effect (if any)
______	☐ Yes ☐ No	______
______	☐ Yes ☐ No	______
______	☐ Yes ☐ No	______
______	☐ Yes ☐ No	______

Now please list any "as needed" medicines that you take now, or have taken in the past, to try to stop the headache, including prescription and over-the-counter medicines. As you did above, please list whether it works/worked, and any side effects.

Medication	Effect?	Side Effect (if any)
______	☐ Yes ☐ No	______
______	☐ Yes ☐ No	______
______	☐ Yes ☐ No	______
______	☐ Yes ☐ No	______

Please write down everything you have eaten and drunk for the past 2 days. Continue on back if more space is required.

Food	Beverage
______	______
______	______
______	______
______	______
______	______
______	______
______	______
______	______
______	______

Migraine Diary

The key to successful migraine treatment is YOU! The more involved you become in your treatment, the more likely you are to get relief from your migraine pain. The Migraine Diary is your most important tool. It helps you and your doctor track your migraines and how well your treatment is working. It will also help you identify migraine triggers that may be causing your migraines.

Record your information as accurately and completely as you can. Then bring your Migraine Diary to your next doctor visit.

How to Use the Migraine Diary

The following instructions will explain how to complete each diary section.

- **Migraine severity**
In this section, each day is broken down into morning, afternoon, and evening. On the days you have migraine pain, write a number in the appropriate box from 1 to 3 that describes your pain: "1" = mild; "2" = moderate; "3" = severe.

Adapted from the New England Center for Headache: Headache Calendar

- **Triggers**
There are many things that can cause (trigger) a migraine. The key on the next 2 pages assigns a number to each trigger. For example, chocolate is No. 6 and strong light is No. 23. Record the numbers of the triggers you have been exposed to on the day of your migraine.

- **For women only: menstrual period**
Some women tend to get migraines around the time of their period. Place an "X" on the days you have your period.

- **Medicines**
Write the names of any medicines, including over-the-counter and prescription, that you take to relieve your migraine pain—including the dose. Below each medicine, use numbers 0 to 3 to indicate the overall level of relief you got from the medicine. For example, "0" = no relief; "1" = slight relief; "2" = moderate relief; and "3" = complete relief.

Migraine Triggers

Use this key to complete the trigger section of the migraine diary

Hormones

1. Menses (period)
2. Ovulation
3. Hormone replacement therapy
4. Oral contraceptives

Diet

5. Alcohol
6. Chocolate
7. Aged cheeses
8. Monosodium glutamate (MSG)
9. Artificial sweeteners
10. Caffeine
11. Nuts
12. Nitrates and Nitrites (found in hot dogs, bologna, and other processed meats)
13. Citrus fruits
14. Other

Changes

15. Weather
16. Seasons
17. Travel (crossing a time zone)
18. Altitude
19. Schedule change
20. Sleeping patterns (erratic or changes in normal patterns)
21. Diet
22. Skipping meals

Sensory stimuli

23. Strong light
24. Flickering light
25. Odors

Stress

26. Let-down periods (vacations, weekends, after a major event)
27. Times of intense activity
28. Loss (death, separation, divorce)
29. Relationship difficulties
30. Job stress, loss, or change
31. Crisis
32. Other

Migraine Diary

MIGRAINE SEVERITY

The diary is numbered 1—31 for each day of the month. On the days you have migraine pain, record in the box the number that describes your migraine pain: **1=mild; 2=moderate; 3=severe**

Day of Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
Morning																															
Afternoon																															
Evening/Night																															

Day of Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
TRIGGERS‡																															
MENSTRUAL PERIOD§																															

‡Triggers
Each trigger has been assigned a number. Record the numbers of the triggers you may have been exposed to on the day of your migraine.

§Menstrual Period
Place an "X" on the days you have your period.

MEDICINES TAKEN

(Record all medicines, including over-the-counter and prescription, used to treat migraine pain and related symptoms)

On the days you take medicines to relieve your migraine pain, write the names of the medicines and the doses in the appropriate box. Place a check (✓) for each dose you take. Also, record in the appropriate box a number from 0 to 3 that describes the amount of overall relief you got from that medicine: **0=no relief; 1=slight relief; 2=moderate relief; 3=complete relief.**

Day of Month		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
Medicine:	Dose:																															
	Overall Relief																															
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The Headache(less) Diet

Foods to Eat	Foods To Avoid		Tips to Follow
Boar's Head Brand meat and cheese (has no additives) Organic chicken broth – Pacific Foods Chicken Broth (has no MSG) Oil and Vinegar dressing – Brianna's French Vinaigrette (has no soy bean oil) Apples, pears, peaches, apricots, strawberries, watermelon and cranberries Carbohydrates from whole grains Ry-Krisp or plain Triscuits crackers (no flavorings other than salt) Green beans and other vegetables Cottage Cheese that doesn't have the "bad ingredients" in it Havarti Cheese Mozzarella Cheese Real American Cheese, including Kraft Deli Deluxe brand which is real cheese	Cheese that contains MSG Canned soups and broths (most contain MSG; a few in the organic aisle **don't** say MSG or natural flavoring and those are OK) Dressings containing the "bad ingredients" (listed below) Citrus fruits and juices, bananas, grapes, pineapple, mango, papaya, cantelope, avocado Minimize simple sugars or white flour carbohydrates Crackers made with soy bean oil Soy sauce, A-1 sauce and Worcestshire sauce Protein bars and drinks (contain too many additives Gatorade, Kool-aid and most sodas (a little caffeine-free ginger ale is OK) NutraSweet, Chocolate, Caffeine (may drink no more than 1 cup of coffee per day—preferably not the strong stuff at Starbucks and avoid the "shots" of extra caffeine) All alcoholic beverages	Minimize tomatoes, onions, dry beans, kidney beans, chick peas, nuts (Minimize means just that; you can have a little but not a lot, and some people are very sensitive to onions and have to avoid altogether) "Bad Ingredients": avoid ingredients that include glutamate, which includes yeast extract, caseinate, gelatin, gums, hydrolyzed vegetable protein, malt or barley extract, modified food starch, maltodextrin, monosodium glutamate or (MSG), "natural" flavor, smoke flavoring, all soy products and whey. **THIS IS A BIG ONE** - almost all migraine patients are sensitive to artificial sweeteners so these must be 100% avoided. This Means No: ▪ NutraSweet ▪ Splenda ▪ Sweet 'n' Low	Drink 2 liters of water or seltzer water per day (not Propel water, which has additives) You want to increase the protein in your diet and decrease carbohydrates Eat a high-protein breakfast every day. Not protein bars or drinks, but rather: Eat a natural protein every 3-4 hrs. like eggs, meat, cheese or cottage cheese—Mozzarella cheese sticks are a good portable snack for mid-morning AND mid-afternoon The best cold cuts without additives are Boar's Head brand—plain roast beef and low-salt turkey only; we don't want the flavorings that are in the mesquite or smoked turkey, or the Italian flavored roast beef, or the nitrites in any of the hams or pastrami, etc, even in Boar's head brand. Examine your salad dressings for the "bad ingredients" listed on the front page. When eating out try simple oil and vinegar. In the grocery store one that doesn't contain soy bean oil is Brianna's French Vinaigrette.