HORIZON HEADACHE CENTER
an integrative, non-narcotic approach to headache management

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Medical History Intake Form

The following questions relate to your general health. The details of this form will only be reviewed by your physician and nurse. Please bring this form to your first appointment.

Headache History

How long have you had headaches? _____

Have you ever been hospitalized for headaches? _____

If so, please list most recent location and dates of hospitalization:

_____
_____
_____
_____
_____

Have you gone the emergency room for headache treatment? _____

If so, please list most recent location and dates of emergency room visits:

_____
_____
_____
_____
_____

At least once a week, do you miss school, work, or social activities because of your headaches? _____

Please list outpatient physician that you have seen for your headaches in the past five years. Include their practice name, specialty, location, and approximate dates you were under care.

_____
_____
_____
_____
_____
_____

How many days in the past month did you have a headache? _____

Past Medical/Surgical History

Have you ever been diagnosed with any of the following health conditions:

Health Condition:	YES	NO	Details/Dates of your condition
EYES:			
Glaucoma			
Retinal Artery Occlusion			
Retinal Migraine			
Cataracts			
Near or far sighted			
Other eye problems			
HEENT:			
Recurrent Ear Infections			
Chronic Sinusitis			
Seasonal Allergies			
NECK:			
Thyroid Problems			
Neck Injury/Pain			
DENTAL:			
Wisdom Teeth Removal			
Root canal			
TMJ disorder			
Bruxism (teeth grinding)			
Orthodontic device (braces)			
CARDIAC:			
Heart attack/Stent placement/Bypass Surgery			
Congestive Heart Failure			
Atrial Fibrillation			
Abnormal heart beat			
Heart murmur			
High Blood Pressure			
High Cholesterol			
Diabetes, specify type:			

Health Condition:	YES	NO	Details/Dates of your condition
LUNGS:			
Pneumonia requiring hospitalization			
Tuberculosis			
Asthma			
COPD/Emphysema			
GASTROINTESTINAL:			
Peptic Ulcer Disease			
GERD/Acid Reflux			
Liver problems			
Kidney Problems			
Irritable Bowel Disease			
Chronic Constipation			
Crohn's Disease or Ulcerative Colitis			
URINARY SYSTEM:			
Kidney Disease/Renal insufficiency or failure			
Kidney Stones			
Interstitial Cystitis			
Recurrent UTI			
Pyelonephritis/Kidney Infection			
FEMALE GYN:			
Abnormal Pap Smear			
Sexually Transmitted Disease			
MALE SYSTEM:			
Prostate cancer			
Benign Prostate Hypertrophy			
MUSCULOSKELETAL:			
Chronic Back Pain			
Shoulder problems			
Injury to any joint/bone			
Osteoarthritis			
Osteoporosis			
RHEUMATOLOGY:			
Fibromyalgia			

Health Condition:	YES	NO	Details/Dates of your condition
Rheumatoid Arthritis			
Other inflammatory arthritis			
SLE (Lupus)			
Scleroderma			
PYSCHIATRIC:			
Depression			
Bipolar/Mania			
Schizophrenia/schizoaffective disorder			
Psychiatric disorder requiring hospitalization			
Suicidal thoughts or attempts			
NEUROLOGIC:			
Headaches/Migraines			
Stroke/Mini Stroke (TIA)			
Seizures			
Brain aneurysm			
Multiple Sclerosis			
Other neurologic condition			
HEME/ONCOLOGY:			
Cancer or Tumor			
Anemia			
Blood clots/ Clotting disorders			

Please list any other medical conditions you have been diagnosed with in your lifetime that was not included above:

_____

_____

_____

_____

_____

_____

Please list any surgeries you have had in your lifetime:

_____

_____

_____

_____

_____

_____

Medications

Please list medications you are currently taking:

Medication	Dose	Frequency	Date Started	Condition being treated

Please list all medications you have tried in the past for your headaches:

Medication	Dose	Frequency	Dates you took this med	Why it was discontinued

Family History:

Do headaches, other neurological disorders, or heart problems run in your family? If so, please explain who and what they have/had?

_____

_____

_____

_____

_____

Please describe any health condition that your mother father or siblings have/had?

Relative	Living or Deceased	Health Conditions
Mother		
Father		

Neuroimaging

Have you had a CAT scan, EEG, or MRI of your head and neck in the past 3 years?

Yes No If so, please bring the report to your initial visit.

Review of Systems

(Please circle YES to any of the following you may have experienced in the past 3 months and use the remarks section below to explain)

GENERAL

Fever, chills, night sweats	YES	NO
Weight change more than 10 lbs.	YES	NO
Overwhelming fatigue	YES	NO

EYES

Temporary vision changes	YES	NO
Permanent vision changes	YES	NO
Blurry vision	YES	NO
Seeing spots or lines of light	YES	NO
Pain in eyes	YES	NO
Increased/Decreased Tearing	YES	NO
Double Vision	YES	NO

HEENT

Scalp Tenderness	YES	NO
Ear pain	YES	NO
Ringing in the ears	YES	NO

Review of Systems, continued

Hearing loss	YES	NO
Vertigo (feeling like the room is spinning)	YES	NO
Pain or numbness in face	YES	NO
Problems with speech or slurred speech	YES	NO
Sore throat	YES	NO
Nasal Congestion	YES	NO
Sinus pain or pressure	YES	NO
CARDIOVASCULAR		
Chest pain	YES	NO
Racing heart rate or irregular heart beat	YES	NO
Pain in legs with walking	YES	NO
LUNGS		
Cough	YES	NO
Shortness of breath	YES	NO
ABDOMEN		
Abdominal Pain	YES	NO
Nausea/Vomiting	YES	NO
Heartburn	YES	NO
Diarrhea/Constipation	YES	NO
Pain or trouble with swallowing	YES	NO
Blood in stool	YES	NO
FEMALE		
Abnormal menses	YES	NO
Pelvic pain	YES	NO
Recent pregnancy	YES	NO
GU		
Trouble with urinary stream	YES	NO
Pain with urination	YES	NO
Frequency of urination	YES	NO
Erectile dysfunction (males)	YES	NO

Review of Systems, continued

SKIN		
Rash	YES	NO
PSYCH		
Feeling sad or down	YES	NO
Feeling anxious or worried	YES	NO
Poor sleep	YES	NO
Feeling overwhelmed	YES	NO
Difficulty concentrating	YES	NO
Mood swings	YES	NO
NEUROLOGIC		
Weakness in arms, legs, or face	YES	NO
Loss of consciousness	YES	NO
Memory problems	YES	NO
Numbness or tingling	YES	NO
Seizure	YES	NO
Poor balance	YES	NO
Tremor	YES	NO
MUSCULOSKELETAL		
Muscle pain	YES	NO
Low back pain	YES	NO
Neck pain	YES	NO
Shoulder pain	YES	NO
Other joint pain, stiffness, or swelling	YES	NO

Review of Systems Remarks (if YES to any of the above, please specify below):

_____

_____

_____

_____

_____

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_____