ATLANTA NEUROLOGY, P.C.
Headache History and Profile Form

Name: _____ Date of Birth: _____ Date: _____

How old were you when you started having headaches? _____

Headache frequency: _____ x/Day _____ x/Week _____ x/Month _____ x/Year _____ Constant

How long do your headaches usually last? _____ Minutes _____ Hours _____ Days _____Constant

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Is the headache getting: □ Better □ Worse □ Fluctuating □ No change

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Rate average level of head pain: □ 1 (slight) □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (severe/worst)

Description of head pain:
□ Throbbing/pulsating □ Pressing/squeezing □ Dull/nagging □ Stabbing □ Electrical

Other, describe: _____

Location of headache:
□ Right side □ Both sides □ Forehead □ Back of head □ Face □ Behind/around eyes
□ Left side □ Either side □ Temples □ Top of head □ Neck □ Other: _____

Do you experience any visual disturbances or changes with headaches? □ Yes □ No

□ Blurred vision □ Partial loss of vision □ Total loss of vision/blindness
□ Double vision □ Spots before eyes □ Zigzag/shimmering lines

How long does the visual disturbance last? □ _____ seconds □ _____ minutes □ _____ hours

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Mark any of the following associated with headache:

□ Light sensitivity
□ Noise sensitivity
□ Odor sensitivity
□ Nausea
□ Vomiting
□ Diarrhea
□ Loss of appetite
□ Eyelid droop □ Right □ Left
□ Tearing □ Right □ Left
□ Eye redness □ Right □ Left
□ Nasal congestion or drainage □ Right □ Left
□ Difficulty concentrating
□ Difficulty talking/finding words
□ Difficulty understanding
□ Tinnitus (ringing in ear)
□ Fainting (feel like or have fainted)
□ Dizziness (lightheadedness)
□ Vertigo (spinning sensation)
□ Neck pain
□ Muscle tightness
□ Numbness Where: _____
□ Weakness to face □ Right □ Left
□ Weakness to arm(s) □ Right □ Left
□ Weakness to leg(s): □ Right □ Left
□ Slurred speech
□ Depression
□ Anxiety
□ Fatigue
□ Irritability
□ Restlessness
□ Decreased jaw opening
□ Jaw pain/pain with chewing

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What are your known headache triggers?

- ☐ Stress
- ☐ Hormonal changes
  - ☐ Birth control pills
  - ☐ Just before/during menses
  - ☐ Menopause
  - ☐ Perimenopause
  - ☐ Pregnancy
- ☐ Sleep
  - ☐ Changes in sleep
  - ☐ Excessive sleep
  - ☐ Lack of sleep
- ☐ Weather changes
- ☐ Mood
  - ☐ Anxiety
  - ☐ Depression
- ☐ Missed meals
- ☐ Medication(s) _____
- ☐ Caffeine
- ☐ Alcohol
- ☐ Artificial sweeteners
- ☐ Cheeses
- ☐ Chocolate
- ☐ Citrus fruits
- ☐ MSG
- ☐ Nitrates
- ☐ Nuts
- ☐ Processed meats
- ☐ Bending over
- ☐ Physical activity
- ☐ Sexual activity
- ☐ Other:_____

Have you hit your head or had any head trauma? ☐ Yes ☐ No When, describe: _____

_____

Prior MRI or CT scan of brain to evaluate for headache cause?

☐ Yes ☐ No When: _____ ☐ Normal ☐ Abnormal ☐ Unknown

Have you been to the ER or urgent care for headache treatment? ☐ Yes ☐ No

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Outside of medication(s), what do you do to treat your headaches?

☐ Activity	☐ Heat	☐ Massage	☐ Rest
☐ Darkness	☐ Ice	☐ Quiet	☐ Relaxation

Are your headaches associated with any of the following:

- ☐ Personal history of cancer
- ☐ Unintentional weight loss
- ☐ Fever
- ☐ New onset of headache (no history of headaches before)
- ☐ Change in normal headaches
- ☐ Headaches starting after age 50
- ☐ Sudden, severe pain within 1 minute (thunderclap headache)
- ☐ Vision changes
- ☐ Pulsative tinnitus (ringing in ear)
- ☐ Gets worse or better when lying down or sitting up
- ☐ Triggered by exertion or activity (i.e. with exercise, coughing, sneezing, having bowel movement)