ATLANTA NEUROLOGY, P.C.

Headache History and Profile Form

Name: ________________________________ Date of Birth: _______________ Date: _______________

How old were you when you started having headache? ____________

How often are your headaches? ____ x/Day ____ x/Week ____ x/Month ____ x/Year ____ x/Constant

How long do your headaches usually last? ______ Minutes ______ Hours ______ Days ______ Constant

Circle one: My headaches are getting: □ Better □ Worse □ Fluctuating □ No change

What is your 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 □ stabbing □dull/nagging □ other

Where are your headaches? □ right side only □ left side only □ both sides □ either side □ across the forehead □ back of head □ face □ behind/around eyes □ temples □ top of head □ neck □ other ___________________

After headache starts does it usually: □ stay in one place □ moves around □ varies □ uncertain

Are your current headaches different than headaches in the past? □ Yes □ No _________________________

Do your headaches wake you up out of your sleep? □ Yes □ No

What other symptoms do you experience with your headaches? Check all that apply.

Visual disturbances or changes: □ Yes □ No

- □ Blurred vision
- □ Double vision
- □ Partial loss of vision/seeing only half of objects
- □ Spots before eyes
- □ Total loss of vision/blindness
- □ Zigzag/shimmering lines
- How long does the visual disturbance last? □ _____ seconds □ _____ minutes □ _____ hours

Eyelid droop □ Right □ Left
Tearing □ Right □ Left
Eye redness □ Right □ Left
Nasal congestion or drainage □ Right □ Left
Difficulty concentrating: □ Yes □ No
Difficulty talking/finding words: □ Yes □ No
Difficulty understanding: □ Yes □ No
Numbness: □ Yes ____________________ □ No
Slurred speech: □ Yes □ No
Tinnitus (ringing in ear): □ Yes □ No
Fainting (feel like or have fainted): □ Yes □ No
Dizziness (lightheadedness): □ Yes □ No
Vertigo (spinning sensation): □ Yes □ No

Nausea: □ Yes □ No
Vomiting: □ Yes □ No
Diarrhea: □ Yes □ No
Loss of appetite: □ Yes □ No
Neck pain: □ Yes □ No
Muscle tightness: □ Yes □ No
Weakness to face: □ Yes □ No (□ Right □ Left)
Weakness to arm(s): □ Yes □ No (□ Right □ Left)
Weakness to leg(s): □ Yes □ No (□ Right □ Left)
Depression/anxiety: □ Yes □ No
Fatigue: □ Yes □ No
Decreased jaw opening: □ Yes □ No
Jaw pain: □ Yes □ No

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

Do you have any blood relatives with headaches? ☐ Yes ☐ No

Have you hit your head? ☐ Yes ☐ No When: ________________________________

Have you had an MRI of CT scan of your brain? ☐ Yes ☐ No When: ________________________________
☐ Normal ☐ Abnormal ☐ Unknown

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

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

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

Have you tried any herbal remedies specifically for your headaches? ☐ Yes ☐ No ______________________

Have you tried headache preventative medications before (medication you take every day with goal of preventing you from have having headaches)? ☐ Yes ☐ No If yes, list:
____
____
____

What abortive medications have you tried (as-needed medications to get rid of your headache)?
____
____
____

How many days of week do you take rescue medications (over-the-counter and/or prescribed medications) to treat your headaches? ______________ /7 days

How many days per month are you headache FREE? ____________ /30 days

---

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
- ☐ Foods
  - ☐ Alcohol
  - ☐ Artificial sweeteners
  - ☐ Cheeses
  - ☐ Chocolate
  - ☐ Citrus fruits
  - ☐ MSG
  - ☐ Nitrates
  - ☐ Nuts
  - ☐ Processed meats
- ☐ Bending over
- ☐ Physical activity
- ☐ Sexual activity
- ☐ Other __________________________