

PINNACLE MEDICAL GROUP

Neurology

7005 Cortez Road W, Bradenton, FL 34210 941-750-0602

Headache

Patient Name: _____ Date: _____

Please mark yes or no and fill in blank spaces

How many months or years have you had headaches?

- Less than 6 months
- 6-12 months
- 1-4 years
- 4 or more years

Do these severe headaches occur on the weekend? Yes No Sometimes

Do they occur at a special time of day? Morning Afternoon Evening

Do they ever wake you from a sound sleep? Yes No

During a typical severe headache, check any of the following which you may experience:

- | | |
|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Avoidance of exercise |
| <input type="checkbox"/> Avoidance of bright lights | <input type="checkbox"/> Behavior changes |
| <input type="checkbox"/> Avoidance of loud sounds | Visual problems: |
| <input type="checkbox"/> Paralysis/weakness of an arm or leg | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Numbness/tingling of an arm or leg | <input type="checkbox"/> Loss of vision |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> Seeing stars |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Unusual flashes of light |

Are you able to identify any pattern to your headaches such as special foods, hunger, lack of sleep, weather changes, etc? Please describe _____

Is there anything that makes the headache worse? Describe _____

What makes you feel better when you have a severe headache? Describe _____

Do you have any concerns about being depressed or anxious? Yes No

If yes, please describe _____

Have there been any recent stresses or changes in your life recently, such as difficulties in school, work or at home? Yes No

If yes, please describe _____

Additional comments you feel your physician should be aware of: _____