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:

❑ Nausea
❑ Vomiting
❑ Avoidance of bright lights
❑ Avoidance of loud sounds
❑ Paralysis/weakness of an arm or leg
❑ Numbness/tingling of an arm or leg
❑ Confusion
❑ Stomach Pain
❑ Fever
❑ Dizziness
❑ Avoidance of exercise
❑ Behavior changes

Visual problems:

❑ Blurred vision
❑ Loss of vision
❑ Double vision
❑ Seeing stars
❑ 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: _____

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