MedStar Georgetown University Hospital

MedStar Georgetown Headache Clinic
New Patient Packet

Please complete the follows:
Name: _____ Date of Birth: _____ Today's Date: _____

If you are transitioning your care from another center, we request you bring your medical records to us within the first 6 months of today's visit. Without these records, we are unable to help you make the best decision for your health.

If you are a woman of reproducing age:
We request that you make your plans for pregnancy clear to the provider as most medication options would not be safe for a woman to continue if she is pregnant. While undergoing treatment we request that our women who are not in menopause use two reliable forms of birth control, unless you have discussed pregnancy planning with your clinician.

Current Complaint: (Briefly describe the reason for your visit to our office today)
_____
_____
_____

Past Medical Problems:
_____
_____
_____
_____

Allergies to Medications:

_____

Current Medications:
Name, Dose, and Frequency
_____
_____
_____
_____
_____
_____
_____

Past Surgeries

_____
_____
_____

Family History of Medical Problems:
Father:_____
Mother:_____
Siblings:_____
Children:_____

Social History:
Who lives with you?
_____
What do you do for work?
_____
Do you use any recreational drugs, and if so, what/how often? _____
Have you ever smoked? ☐ Yes ☐ No
Do you presently smoke? ☐ Yes ☐ No (If you smoke, how many a day? _____)
If you smoke now, or did so previously, for how many years did you smoke? _____
If you have quit smoking, how long has it been since you quit? _____
Do you drink alcoholic beverages, and if so, what/how much? _____
Do you drink caffeinated beverages, and if so, what/how much? _____
Do you exercise, and if so, what do you do and how often?
_____

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HEADACHE HISTORY

PLEASE CIRCLE YOUR RESPONSE

ONSET OF FIRST HEADACHE:

Headaches started _____ years ago.
I was: younger than 20 20-30 30-50 over 50 years old

PRECIPITATING EVENT (trigger of first headache):

None Known Injury
Menarche (first period) Pregnancy
Other:_____

FREQUENCY:

Headaches occur _____ times each Day Week Month

ONSET:

Headache onset occurs: gradually suddenly varies
And most frequently in the: morning afternoon evening night

LOCATION:

Starts: left side of head right side of head either side of head both sides of head
back of head neck behind eye(s) other: _____

DURATION:

Last ____ hours days WITHOUT medications
Last ____ hours days WITH medications

INTENSITY:

Without medication: mild moderate severe incapacitating

DESCRIPTION OF PAIN TYPE:

throbbing aching pressure stabbing shooting tight
dull burning searing other: _____

HEADACHES EFFECT ON ABILITY TO FUNCTION:

Able to function normally
Ability to function slightly decreased
Ability to function severely decreased
Totally bedridden

HORMONAL:

Headaches are affected by: menstrual cycle pregnancy
How? _____

FREE OF HEADACHE from: _____ to _____ never free

If never free, when was the last time you went 24 hours without headache? _____

HEADACHES CAN BE BROUGHT ON BY:

fatigue	physical exertion	stress	weather changes	hunger
lack of sleep	menstruation	loud sounds	high altitude	alcohol
too much sleep	odors	coughing	bright lights	medications
chewing or talking	sex/orgasm	foods (which?_____)		

other: _____

WARNINGS THAT A HEADACHE IS COMING:

light flashes	numbness	upset stomach	zigzag lines
dizziness	weakness	blindness	lightheadedness

other: _____

ASSOCIATED SYMPTOMS:

nausea/vomiting	one eye tears	sore/stiff neck	ringing in the ears	poor concentration
numbness/tingling	both eyes tear	concentration	lightheadedness	dizziness
increased urination	constipation	diarrhea	fatigue	weakness
blurred vision	increased appetite	decreased appetite	insomnia	mood changes

other: _____

Sensitive to: lights sounds smells motion

DURING A HEADACHE, YOU ARE MORE COMFORTABLE:

lying down	with massage or pressure on scalp	when pacing
in a dark, quiet room	with hot or cold compress	chewing or talking

other: _____

PREVIOUS NON-MEDICAL TREATMENTS AND EVALUATIONS:

biofeedback/relaxation/self hypnosis	physical therapy	chiropractor
acupuncture/acupressure		

other: _____

Previous Neurologist/PCP:

Diagnostic Testing/ Other: If yes, please provide dates and where test where completed

MRI Brain: Yes/No _____ MRA Brain: Yes/No _____

MRI Cervical Spine: Yes/No _____ Sleep Study: Yes/No _____

Other: _____

Review of Systems

Please circle if you have experienced any of the following in the last one year:

General
Weight gain
Weight loss
Trouble sleeping
Vision
Blurred vision
Loss of vision
Ear, Nose, and Throat
Ringing in the ears
Hearing loss
Loss of vision
Cardiovascular
Chest Pain
Palpitations
Respiratory
Chronic cough
Shortness of breath
Gastrointestinal
Abdominal Pain
Change in bowel habits
Genitourinary
Pain when voiding
Frequent urination
Dribbling after urination
Endocrine
Hair loss
Hematology
Easy bruising
Musculoskeletal
Back pain
Neck pain
General joint pain
Dermatological
Rashes
Neurological
Numbness
Headache
Psychiatry
Depression
Anxiety

Last Menstrual Period: _____
Are you using birth control: Y N
Please circle: Condoms Oral Birth Control IUD
Are you planning pregnancy in the next 6 months-1 year: Y N

Circle medications you have taken in the past, and write how long you were on them next to the medication (For ex – 2 months, or from 1/3/15-6/1/15)

Prophylactics	**Procedures (Please list how many times/effective)**
Oral medication	Greater Occipital Nerve Block
Atenolol	Trigeminal Nerve Block
Bystolic	Sphenopalantine Nerve Block
Metoprolol/Toprol/Lopressor	Trigger Point Injections (where on the body?)
Nadolol/Corgard	Cervical Facet Blocks
Propranolol/Inderal	Radiofrequency Ablation
Timolol	
Cardizem	**Rescue Medications**
Nifedipine	Tylenol
Norvasc	Ibuprofen/Advil/Motrin
Verapamil	Naproxen/Aleve
Clonidine	Aspirin
Candasartan/Atacand	Excedrin
Lisinopril	Goody's Powder
Acetazolamide	BC Powder
Carbamazepine/Tegretol	Celebrex
Depakote/Valproic Acid	Diclofenac
Lamictal	Etodolac/Lodine
Phenobarbital	Indomethacin/Indocin
Topiramate/Topamax	Meloxicam/Mobic
Trileptal	Nabumetone/Relafen
Zonisamide/Zonegran	Toradol/Ketorolac (Pill or Injection or Nasal- circle all that apply)
Amitriptyline/Elavil	
Desipramine	Steroid dose pack (Type/Dose:)
Nortriptyline/Pamelor	Olanzapine/Zyprexa as needed
Duloxetine/Cymbalta	Chlorpramizine/Thorazine as needed
Venlafaxine/Effexor	Quetiapine/Seroquel as needed
Lithium	
CGRP monoclonal antibodies	Almotriptan/Axert
Aimovig	Eletriptan/Relpax
Ajovy	Frovatriptan/Frova
Emgality	Naratriptan/Amerge
Neurotoxin	Rizatriptan/Maxalt
Botox for Chronic Migraine (How many times?)	Sumatriptan/Imitrex/Treximet (oral, nasal, injection- circle all that apply)
Devices	Zolmatriptan/Zomig (oral, nasal, other- circle all that apply)
Cefaly	
sTMS	DHE-45 injection
Gammacore	DHE-45 nasal (Migranal)
Other :	Ergomar
	Other:

Pharmacy Benefits Carrier: CVS Caremark, Optum RX, Express Scripts
Other: