

**Clinical Research Institute
Migraine Medical History Form**

Please fill out this form as completely as possible and bring it to your first research study appointment.

Name: _____ DOB: _____ Today's Date: _____

Headache History Questions

HOW MANY TYPES OF HEADACHES DO YOU HAVE:

- Migraine Frequency _____ times/ month Sinus Frequency _____ times/ month
 Tension Frequency _____ times/ month Cluster Frequency _____ times/ month

HOW DO YOU TELL THE DIFFERENCE BETWEEN YOUR DIFFERENT TYPES OF HEADACHES:

Migraine History

ONSET YEAR: _____ AGE AT ONSET _____

PRIOR DIAGNOSIS OF MIGRAINE: Yes No

if yes, made by _____ date of diagnosis _____

Do your migraine headache attacks last 4 to 72 hours?? _____yes _____no

LOCATION OF HEADACHES: right sided left sided all over front back of head
 other _____

DESCRIBE YOUR UNTREATED MIGRAINE PAIN INTENSITY _____Mild _____ Moderate _____ Severe

Do you have an AURA before pain starts?? (flashing lights, holes in vision) _____yes _____no

ASSOCIATED SYMPTOMS: circle all that apply

Light sensitive	Vomiting	runny nose	dizziness	diarrhea
Sound sensitive	aggravated by physical activity	watery eyes	weakness	blurred vision
Nausea	pulsating pain	nasal congestion	numbness	paralysis

DO YOU HAVE A FAMILY HISTORY OF MIGRAINE?: _____

CARDIAC HISTORY: chest pain yes no diabetes yes no
 tobacco use yes no hypertension yes no
 high cholesterol yes no

PREVIOUS MIGRAINE MEDICATIONS/TREATMENTS: check all that apply

- Imitrex Axert Relpax Frova Amerge Maxalt Zomig
 NSAIDS Narcotics Ergotamine Tylenol Other _____

PREVIOUS TESTS: CT scan Date _____ MRI Date _____

Social History:

Do you or did you smoke tobacco? No Yes – what type (circle) Cigarettes Pipe Cigars

Chew tobacco? No Yes

How many years did you or have you smoked? _____ If no longer smoking, date stopped _____

If cigarettes, how many packs per day do you or did you smoke? _____

How many alcoholic beverages do you have per week? _____ Per day? _____

Drug Allergy: No Yes

Name of drug: _____ Circle reaction: Hives Rash Itching Asthma Shock Other _____

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Please tell us if you currently have or have had a past history of any of the following conditions. If you answer yes, please circle condition and give dates that the condition started, stopped or if it is continuing.

Head/Ears/Eyes	Problems with your eyes, ears or throat?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Allergies:	Seasonal, year round?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Nose/Throat	Speech or hearing problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Headaches (cluster, tension, migraines) or seizures?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Sinus problems (loss of smell, polyps, infection)?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Mouth/throat problems (infections, hoarseness)	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Problems with vision?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Emotional:	Do you feel nervous, angry, suicidal, depressed, lonely, sad or out of control?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Do you have trouble sleeping?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Endocrine:	Diagnosed with diabetes? When/type _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Do you have thyroid disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Cataracts?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Circulatory:	Heart problems (high blood pressure, palpitations, chest pain, irregular heart beat)?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Respiratory:	Lung problems (asthma, bronchitis, pneumonia, TB, emphysema)?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Gastrointestinal:	Recent problems with eating, drinking?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Problems with nausea, vomiting, abdominal pain, or bloody stools?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Recent weight changes or change in appetite within the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Ulcers, hernias, indigestion, cirrhosis, or hepatitis?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Genital/Urinary:	Burning, pain or frequency when urinating?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Have you been treated for a sexually transmitted disease? If yes, what _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Have you had kidney stones, prostate infection (male), or urinary tract (bladder) infection?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Immune:	Cancer, blood diseases, deficiencies, anemia?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Mobility:	Muscular/joint (i.e. arthritis) bone/orthopedic problems or difficulty with coordination?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Skin:	Problems with your skin (rash, hives, changes in skin/hair, cold sores, eczema)?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____

Have you ever had surgery? ____ No ____ Yes – Describe date and type of surgery.

Have you ever been hospitalized except for a surgery? ____ No ____ Yes – Describe _____

MEDICATIONS –list all medications (including prescription and over-the-counter) used in the past 6 months.

<u>Medication</u>	<u>Dose</u>	<u>Reason for use</u>	<u>Date started</u>	<u>Date stopped</u>
<i>(example) ibuprofen</i>	<i>2-200 mg tabs</i>	<i>tension headache</i>	<i>April 1, 2003</i>	<i>April 2, 2003</i>
