



421 West Riverside Avenue, Spokane, Washington 99201 Phone: 509.863.9789 Fax: 855.630.0757 Web: www.northwestpaincare.com

Headache Follow-up Visit Form

We will be unable to see you unless this form is completely filled out. We appreciate your thoroughness.

Name _____ DOB _____ Age _____ Today's Date _____

Referring doctor: _____ Primary doctor: _____

Neurologist: _____ Pharmacy: _____

Where is your headache located? _____

What does it feel like? Please check all that apply.

- Aching**
- Dull**
- Pulsating**
- Sharp**
- Throbbing**

How many headaches have you had in the last month? _____

Of these headaches, how many are migraines? _____

On average, how many hours do the migraine headaches last? _____

Are the headaches: Mild Moderate Severe

Does nausea accompany the headaches? Yes No

Does vomiting accompany the headaches? Yes No

Are the headaches worsened by light? Yes No

Are the headaches worsened by sound? Yes No

Are the headaches worsened by smell? Yes No

Rate your pain on a scale of 0 to 10. 0 is no pain and 10 is the worst pain imaginable.

Current pain: ___/10 **Average pain:** ___/10 **Least pain:** ___/10 **Worst pain:** ___/10

Rate your activity level on a scale of 0 to 10. 0 is no activity and 10 is full activity.

Average activity: ___/10 **Least activity:** ___/10 **Most activity:** ___/10

Since your last visit, has your use of pain medication: **Decreased** **Increased** **Not Applicable**

Do you drink caffeine? Yes No

Cups of coffee per day _____ Cups of (caffeinated) tea per day _____ Sodas per day _____



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Review of Systems: Please check ALL that currently apply to you.

Constitutional:

- Chills Fatigue Recent Fever Generalized Weakness
 Recent Weight Gain Recent Weight Loss

Eyes:

- Blurry vision Cataracts Eye discharge Double vision Excessive tearing
 Eye pain Eyeglass use Glaucoma Eye infections Pain w/ light
 Recent eye injury Eye redness Vision loss

ENT:

- Nasal discharge Frequent colds Hay fever Nasal obstruction Recent nose bleeds
 Chronic sinusitis Recent gum bleeding Change in dentition Recent hoarseness Dentures
 Ear discharge Dizziness Hearing aid use Ear infections Ear pain
 Ringing in the ears Hearing loss Frequent sore throats Neck tenderness Enlarged tonsils
 Neck mass

Respiratory:

- Asthma Recent cough Recent wheezing Bronchitis Coughing up blood
 Pleurisy (Pain with Breathing) Shortness of Breath Sputum production History of TB
 Recent pneumonia Recent night sweats Recent chest wall pain

Cardiovascular:

- Recent chest pain Congestive heart failure Palpitations Varicose veins
 Cool extremities Discolored extremities Heart murmur High blood pressure
 History of heart attack Leg pain while walking History of rheumatic fever
 Shortness of breath with exertion Leg swelling Leg ulcers Mitral valve prolapse
 Unable to breathe while flat Difficulty breathing

Gastrointestinal:

- Recent abdominal pain Recent constipation Recent Diarrhea Recent heartburn
 Jaundice Liver disease Rectal bleeding Black, tarry stools
 Recent change in stool color Decreased appetite Excessive Thirst Gallbladder disease
 Hemorrhoids Recent nausea Recent vomiting Difficulty swallowing
 Bloody stools Hepatitis C Hepatitis B Hepatitis A
 Vomiting up blood Increased appetite

Musculoskeletal:

- Arthritis Joint pain Gout Back problems Joint stiffness
 Muscle cramps Muscle stiffness Muscle weakness Neck problems Mid-back problems

Psychiatric:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Recent anxiety | <input type="checkbox"/> Recent depression | <input type="checkbox"/> Recent behavioral change | <input type="checkbox"/> Recent disorientation |
| <input type="checkbox"/> Disturbing thoughts | <input type="checkbox"/> Excessive stress | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Mood changes | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Bipolar disease |
| <input type="checkbox"/> Paranoia | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Personality disorder | <input type="checkbox"/> Previous psychiatric care |
| <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Inability to sleep | <input type="checkbox"/> Obsessive/Compulsive | <input type="checkbox"/> Nervousness |

Skin:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Itching | <input type="checkbox"/> Dryness | <input type="checkbox"/> Easy Bruisability | <input type="checkbox"/> Hair texture change |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Lumps | <input type="checkbox"/> Increased mole size | <input type="checkbox"/> Nail changes | <input type="checkbox"/> Recent rashes |
| <input type="checkbox"/> Skin color change | <input type="checkbox"/> New skin moles | | | |

Neurological:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Burning sensation | <input type="checkbox"/> Dizziness | <input type="checkbox"/> History of head injury | <input type="checkbox"/> Recent headaches |
| <input type="checkbox"/> Recent memory loss | <input type="checkbox"/> Recent numbness | <input type="checkbox"/> History of paralysis | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Recent tingling | <input type="checkbox"/> Recent tremors | <input type="checkbox"/> Unsteady gait | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Discoordination | <input type="checkbox"/> Recent passing out | <input type="checkbox"/> Speech difficulty | |

Endocrine:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Intolerance to cold | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Intolerance to heat | <input type="checkbox"/> Increased thirst | <input type="checkbox"/> Recent sweats | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Excessive urination |

Hematological/Lymph:

- | | | | |
|--|--|--------------------------------------|--|
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Radiation exposure |
| <input type="checkbox"/> Transfusion reaction | <input type="checkbox"/> Tender lymph nodes | | <input type="checkbox"/> Swollen lymph nodes |
| <input type="checkbox"/> Current Blood thinner use | <input type="checkbox"/> History of blood transfusions | | <input type="checkbox"/> Easy bruising |

Allergy/Immunologic:

- | | | | | |
|---|--------------------------------------|--|--|---|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Itchy nose | <input type="checkbox"/> Recurrent infections | |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Food allergies |
| <input type="checkbox"/> Insect allergies | <input type="checkbox"/> Dye allergy | <input type="checkbox"/> Pollen/Seasonal allergy | <input type="checkbox"/> Environmental allergy | |

Urinary:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Difficulty starting stream | <input type="checkbox"/> Recent flank pain | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Urine odor | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Sexual difficulty | <input type="checkbox"/> Frequent UTI's | <input type="checkbox"/> Urinary burning | <input type="checkbox"/> Unusual urine color |
| <input type="checkbox"/> Elevated creatinine | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Painful menstrual cycle | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Urinary retention |
| <input type="checkbox"/> Kidney transplant | <input type="checkbox"/> Awakening to urinate | <input type="checkbox"/> Nighttime Urination | <input type="checkbox"/> Urgent Urination |

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Smoking:

Have you stopped smoking since the last visit?

Yes No

When did you quit smoking?

Month _____ Day _____ Year _____

Have you started smoking since the last visit?

Yes No

When did you start smoking?

Month _____ Day _____ Year _____

Do you smoke every day?

Yes No

Do you smoke some days?

Yes No

How much do you smoke?

Packs _____ per day.

Please draw on the diagram where your headache is:

