Name: _____

Date: _____

# HEADACHE HISTORY

Headache patients are not all the same, so in order to ensure we can provide you as accurate a diagnosis as we can, we ask your assistance in filling out the following form as completely and accurately as possible. This will allow us to begin on your initial visit the process of getting any further testing completed, though most importantly it usually also allows us to begin treatment at that first visit by our having received this fully completed.

Further, copies of all prior neurological or headache specialist evaluations; radiological studies; laboratory studies, along with CD copies of all your radiological studies are required prior to your initial evaluation. Some patients find it helpful to include copies of their pharmacy records for the duration of physician treatment of their headaches, and this is very much appreciated, as well.

Not all questions may pertain to you. The more complete your information you provide on this form, the better we can design your plan of care and thus optimize your time at your initial appointment. This is usually best accomplished by completing it prior to the initial evaluation, not in the waiting room in a hurry prior to being seen as most likely you cannot complete the form then and your initial evaluation will need to be rescheduled. If you have questions, please contact us so we can assist you.

Again, as this is an extensive amount of information, it is not generally recommended to wait until you arrive at the office to begin the process of filling out this Headache History form. If you prefer to do so, we recommend that you arrive at least an hour prior to your scheduled visit with all of your records to assist in this process, and understand that we may have to reschedule your initial evaluation if these forms are not entirely completed in time for your scheduled appointment.

This form is in addition to the basic forms all new patients are asked to complete, as this one is only concerned with the symptom of headache.

We appreciate your time and effort in providing us an accurate, complete record of your headache history so we can be better prepared to help you!

Name: _____

Date: _____

At what age did you first start having headaches? _____

Does anyone else in your family have headaches? Y N Who?_____

How long was the longest headache you've had (treated or untreated)? _____

What is the longest period of time you have not had a headache for? _____

Currently, do you have a headache all of the time? Yes No

If so, how long have you "kept" this headache"? _____

Does it feel like your "typical" headache, or is this one different? _____

Did this change from having episodic headaches occur suddenly or gradually?_____

If your headache isn't there all the time, over the last six (6) months please estimate on how many days per month you have had a headache. _____

Is your headache problem getting worse? Yes No

Is it becoming more frequent, more severe, lasting longer? _____

If your headache problem has changed, when exactly did that occur? _____

Please list if something occurred prior to this change in your headaches (e.g., an illness, an accident, a significant emotional event)._____

Do you go to the emergency room/acute care facility for headache? Yes No

Have you ever been admitted to the hospital to treat your headache? Yes No

Have you ever seen a headache specialist? Yes No Who? _____

Do your headaches appear to be more prominent or only occur at certain times of the year?

_____

Do your headaches seem to occur at certain times of the day? _____

Name: _____

Date: _____

Do headaches wake you up in the middle of the night? Yes No

Do you commonly wake up at your normal time in the morning with a headache? Yes No

How long does it take for your headache to reach how bad it is going to get (in other words, how long is the build-up time for the pain) if you don't take any medication? _____

Where on your head does your headache typically start? _____

When fully developed, what part of the head is then involved in the pain? _____

How bad is the pain typically: 0 is no pain, 10 is the worst pain imaginable? _____

Untreated, how long does the headache typically last? _____

What is the best way to describe the type of pain that the headache is?_____

_____

Does the pain you have with the headache throb? Yes No

Are there any particular triggers which seem to provoke your having a headache:

Foods:

- tyramine (found in chocolate; aged cheeses; vinegar; organ meats; sour cream; soy sauce; yogurt; yeast extracts)
- nitrites (found in smoked fish; pepperoni; hot dogs; bologna; bacon; corned beef; pastrami; canned ham; sausages)
- sulfites; phenylethylalanine; tannins
- MSG (found in dry roasted nuts; potato chips; Chinese food; processed or frozen food; soups and sauces; diet foods; salad dressings; and mayonnaise)
- dehydration, fasting, or skipping meals
- alcohol (red wine; brandy; least likely—scotch, vodka, and Rieslings)
- vitamins (A and B, esp. niacin)
- caffeine or not enough caffeine
- dairy products
- soy beans
- wheat products
- onions
- fatty foods
- seafood
- aspartame (Nutrasweet) or other artificial sweeteners

Name: _____

Date: _____

- beans; chiles; licorice; fried foods; peanuts; popcorn; nuts/seeds

Hormones:

- onset of your menstruation
- menstrual periods (or before they start)
- time of ovulation (generally two weeks before your period)
- use of hormones/birth control pills
- pregnancy or after pregnancy
- menopause/premenopause

Changes:

- weather
- barometric pressure
- seasons
- travel, especially across time zones
- altitude
- schedule changes
- sleeping patterns
- oversleeping
- undersleeping
- skipping meals
- fatigue
- riding in a car
- vacations

Sensory stimuli:

- strong lights
- glare
- flickering lights
- strong smells
- head jarring
- hunger
- position
- sexual activity
- sneezing
- straining
- stress (or after done with the stress)
- touching
- bending over
- chewing
- coughing
- loud noises
- reading in a car
- eating cold foods/drinks ("ice cream headache")
- lack of caffeine

Name: _____

Date: _____

Allergies or sinusitis

Stress:

- intense emotional stress
- intense exercise
- changes in stress levels
- periods after stress has resolved
- relationship problems
- work-related problems

Is there anything you can do to make your headache less severe? _____

Is there anything you can do to make you headache go away? _____

Can you sleep off your headaches? Yes No

What do you typically do when you have a headache, especially a severe one? _____

_____

Some patients can have symptoms which lead them to know ahead of time that they're going to get a headache in a day or so, or their close family or coworkers notice these and tell them so. Do you (or have others told you that you) have any of the below symptoms which could predict your having a headache in the next day or so?

| | | |
|---|---|---|
| mental slowness | light sensitivity | stiff neck |
| depression | poor concentration | food cravings |
| hyperactivity | smell sensitivity | cold feelings |
| fatigue | sound sensitivity | loss/increase of appetite |
| euphoria | problems talking | sluggishness |
| talkativeness | sleep too much | diarrhea |
| irritability | yawning | constipation |
| drowsiness | muscle aches | nose bleed |
| malaise/feeling bad | hot ears | thirst |
| restlessness | | urination |
| surge of energy | | fluid retention |

Name: _____

Date: _____

Just before having a headache, within a few hours of the head pain's starting, do you have any symptoms such as:

| | | |
|---|---|---|
| visual loss or changes | seeing dots | seeing zigzag lines |
| numbness | dizziness | tunnel vision |
| tingling | language problems | emotional changes |
| tunnel vision | lightheadedness | inspiration or other religious experience |
| vertigo | hearing issues | change/loss of taste |
| change/loss of smell | things look too small | touch sensitivity |
| things look too large | tongue numbness | lips numb/tingling |

If so, do they stop before the headache starts or do they continue through into the headache? _____

If they stop prior to the head pain, how long do these symptoms last before the head pain starts? _____

If they stop prior to the beginning of the head pain, how long is that gap in time?

_____

For visual symptoms prior to a headache, do you have them without ever developing the headache? Yes No

During the actual head pain itself, do you have any of the below symptoms:

| | | |
|---|---|---|
| loss of appetite | nausea with or w/o vomiting | smell sensitivity |
| light and/or sound sensitivity | lightheadedness | clumsiness |
| mood changes | visual blurring | vertigo |
| concentration difficulties | excess hot or cold feelings | tremors |
| diarrhea | fluid retention | slurred speech |
| feeling need to have a BM | constipation | pale |
| abdominal cramps | feeling poorly | double vision |
| cold hands/feet | loss of appetite | weakness |
| nasal congestion/drainage | fever/chills | excess urination |
| runny eyes | facial flushing | teeth grinding |
| change in pupil size | scalp tenderness | fatigue |
| red eyes | lack of coordination | insomnia |
| eyelid swelling | irritability | visual loss |
| droopy eyelid | loss of depth perception | passing out |

Name: _____

Date: _____

| | | |
|---|---|---|
| facial swelling | uncontrolled bowels | uncontrolled bladder |
| amnesia | neck pain/tenderness | language problems |
| blindness | confusion | shoulder stiffness |
| problems talking | ear ringing | hearing loss |
| numbness | tingling | "spacey" feeling |
| neck tenderness | goose bumps | |

Does the headache get worse with bending over, climbing stairs, walking? Yes No

Does having a headache keep you from doing your normal daily activities, working, or prevent your doing enjoyable activities? Yes _____ No

When you don't have a headache, do you have:

| | | |
|---|---|---|
| spots or dots or temporary visual loss on standing up quickly | Yes | No |
| excessive blurry vision | Yes | No |
| double vision | Yes | No |
| ringing in your ears (and does it throb with your pulse if you have it) | Yes | No |
| recent weight gain | Yes | No |

Do you have any of the following symptoms as new symptoms:

| | | |
|---|---|---|
| does your headache come on or worsen dramatically on standing or sitting? | Yes | No |
| does your headache start on getting out of bed and then worsen throughout the day? | Yes | No |
| can you have little to no headache in the morning but every afternoon you develop a severe one? | Yes | No |
| do you have any fluid leaking out of your ears or nose? | Yes | No |
| do you have excessive postnasal drop which isn't related to allergies? | Yes | No |
| did you have the sudden appearance of this headache? | Yes | No |
| is this headache often very severe, nearly daily being very severe? | Yes | No |
| are you much more fatigued since having this new headache? | Yes | No |
| does your headache get better in a few minutes of laying down without going to sleep? | Yes | No |
| do you have dizziness/lightheadedness/vertigo/imbalance generally since this headache started? | Yes | No |
| do you have more of these when the headache is worse? | Yes | No |
| did you have any head or spine trauma prior to this new headache? | Yes | No |
| do you have a new metallic taste in your mouth? | Yes | No |
| do you now have significant neck pain or pain in the back of your head? | Yes | No |
| has your hearing worsened since this headache started? | Yes | No |
| is your hearing impaired (for example, muffled) when this headache is very severe? | Yes | No |
| do you have any new ringing in your ears? | Yes | No |
| when the headache is particularly severe, do you have any double vision? | Yes | No |
| is there very prominent blurry vision with this headache? | Yes | No |

is there a family history of any of the following diseases:

| | | |
|---|---|---|
| Marfan's syndrome | Yes | No |
| Ehlers-Danlos syndrome | Yes | No |
| Polycystic kidney disease | Yes | No |
| neurofibromatosis? | Yes | No |

Name: _____

Date: _____

| | | |
|---|---|---|
| Do you have any facial pain or facial numbness with this headache? | Yes | No |
| Are you clumsy with this headache? | Yes | No |
| Newly diagnosed stroke? | Yes | No |
| Any new slurred speech? | Yes | No |
| Any new problems swallowing? | Yes | No |
| Any new tremor? | Yes | No |
| Any new neck, low back, or spine area pain? | Yes | No |
| Any new arm or leg pain? | Yes | No |

After the head pain is gone, do you have any of the following symptoms:

| | | |
|---|---|---|
| changes in thirst | Yes | No |
| changes in appetite | Yes | No |
| head soreness or tenderness or sensitivity | Yes | No |
| trouble thinking | Yes | No |
| fatigue/drowsiness | Yes | No |
| feeling "hungover" | Yes | No |
| nausea | Yes | No |
| vomiting | Yes | No |
| diarrhea | Yes | No |
| constipation | Yes | No |
| weakness | Yes | No |
| mood changes | Yes | No |

Have you had any testing done for your headaches? If so, **please ensure we got a copy of the films themselves and the report from the radiologist who read the studies**.
Examples include:

MRI brain
MRI cervical spine
MR angiogram of neck/head
MR venogram of head

CT brain
CT sinuses

TMJ (temporomandibular joint) x-rays

Spinal tap/lumbar puncture
EEG
Sleep test
Ultrasound of carotid arteries
Echocardiogram

Name: _____

Date: _____

Have you ever had any significant head or neck trauma or a concussion? Yes No
If so, how many times? _____ and when was the last episode? _____

Do you have a history of heart problems or stroke/mini-strokes? Yes_____ No

Have you ever been diagnosed with "complicated migraine"? Yes No

Does anyone in your family have a history of heart problems (heart attack, e.g.) prior to age 60?

Yes _____ No

Does anyone in your family have a history of stroke or mini-stroke prior to age 60?

Yes _____ No

Do you or does anyone in your family have a history of seizures or epilepsy (includes petit mal, grand mal, febrile)? Yes _____ No

Is there any pending legal action related to your headaches? Yes _____ No

Have you ever had any use or abuse of illicit drugs (including but not limited to marijuana, cocaine, heroin, crystal meth, Ecstasy)? Yes _____ No

Do you or does anyone in your family have a history of problems getting pregnant or a history of multiple miscarriages? Yes _____ No

Do you or does anyone in your family have a history of emotional/psychiatric problems, such as anxiety, depression? Yes _____ No

Does anyone in your family have a history of:

| | | |
|---|---|---|
| fibromyalgia syndrome | Yes | No |
| chronic widespread pain | Yes | No |
| chronic fatigue syndrome | Yes | No |
| interstitial cystitis | Yes | No |
| IBS (inflammatory/irritable bowel disease) | Yes | No |
| multiple chemical sensitivity syndrome | Yes | No |

Name: _____

Date: _____

idiopathic environmental intolerance syndrome? Yes No
chronic fatigue and immune dysfunction syndrome? Yes No

Do you have any neck pain? Yes No

Has anyone suggested you try any of the below for muscle spasm treatment?

**GABA agonists:**

Baclofen (lioresal)
Klonopin (clonazepam)
Soma (carisoprodol)
Parafon Forte (chlorzoxazone)
Flexeril (cyclobenzaprine)
Dantrium (dantrolene)
Skelaxin (metaxalone)
Robaxin (methocarbamol)
Norflex (orphenadrine)
Zanaflex (tizanidine)
benzodiazepines (Valium; Ativan)
Neurontin (gabapentin)
Lyrica (pregabalin)
barbiturates
various agents of chemodenervation
sodium oxybate (GHB)
Depakote (VPA)
Topamax (TPM)
Zonegran (zonisamide)
Ambien (zolpidem)
Sonata (zaleplon)
Lunesta (eszopiclone)
Sabril (vigabatrin)
Romazicon (flumazenil)
Diprivan (propofol)
Gabitril (tiagabine)
Ztalmy (ganaloxone)
progesterone
+/- Lamictal (lamotrigine)
+/- Keppra (levetiracetam)

**GLU antagonists:**

Namenda (memantine)

Name: _____

Date: _____

ketamine (Spravato NS)
dextromethorphan
magnesium
amantadine
meperidine
Haldol (haloperidol)
Felbatol (felbamate)
Strattera (atomoxetine)
Nuedexta
Fycompa (perampanel)
nitrous oxide (NO)
methadone
Darvon (dextropropoxyphene)
Ultram (tramadol)
Ketogan (ketobemidone)

**GLY antagonists:**

Procardia (nifedipine)
Cardene (nicardipine)
levophanol
Tofranil (imipramine)
Lasix (furosemide)
flurazepam (Dalmane)
Rohypnol (flunitrazepam)
Rilutek (riluzole)
Calan (verapamil)

**Foods:**

fermented ones (kimchi, miso, tempeh)
green tea
black tea
oolong tea
brown rice
soy beans
adzuki beans
chestnuts
mushrooms
tomatoes
spinach

Name: _____

Date: _____

broccoli
cabbage
cauliflower
Brussels sprouts
sprouted grains
sweet potatoes
aspartame (NMDAR antagonist)
caffeine (glycine antagonist)

**Other:**

Physical therapy
Chiropractic therapy (no spinal manipulation)
Massage therapy
Yoga/tai chi/other similar activity
acupuncture
transdermal options

If you don't feel rested on awakening in the mornings most of the time, please answer the following questions:

| | |
|---|---|
| Do you wake up a lot at night not knowing why? | Yes No |
| Do you snore, or has someone told you that you snore? | Yes No |
| Do you have relatives who snore, especially snore loudly? | Yes No |
| Are you tired during the day most days? | Yes No |
| If you can nap, do you feel refreshed afterwards? | Yes No |
| Do you fall asleep quickly when you go to bed? | Yes No |
| If not, how long does it usually take you to fall asleep? _____ hours | |
| Do you have uncontrollable sleep attacks? | Yes No |
| Do you ever have spells of losing control over your muscles especially when crying or laughing hard? | Yes No |
| Do you have vivid dream-like visions on falling asleep or prior to waking up? | Yes No |
| Have you ever had sleep paralysis? | Yes No |
| Do you have a problem with losing control of your bowels or bladder when you're sleeping? | Yes No |
| Do you sleepwalk, or did you sleepwalk when younger? | Yes No |
| Do you commonly wake up with a headache? | Yes No |
| Do you commonly wake up with a sore throat? | Yes No |
| Do you have pain that keeps you from falling asleep or staying asleep? | Yes No |
| Do you have leg movements that keep you from falling asleep or staying asleep? | Yes No |
| Do you have, especially in the evenings, uncomfortable numb, tingly, creeping, or crawling sensations in your legs, which may be made less severe when you move your legs? | Yes No |
| Do you grind your teeth, especially when sleeping? | Yes No |
| Have you ever had TMJ? | Yes No |

Name: _____

Date: _____

Has any regular bed partner ever complained about your sleep? Yes No

If you drink caffeine daily, about how many servings? _____

Do you have environmental allergies ("hay fever"), allergic rhinitis? Yes No

Do you take any medications more than twice weekly to treat pain or headache, over-the-counter or prescription ones (including Tylenol, Advil, Motrin)?

Which one(s)? _____

How many times a day? _____

How many times in a week? _____

Do you have any of the following symptoms when you don't/when you didn't (if you have a headache all of the time) have a headache?

lightheadedness, sometimes called pre-syncope (pre-fainting) or dizziness (but not vertigo, or room spinning):
dysequilibrium/imbalance:
exercise intolerance:
extreme fatigue:
weakness:
syncope (fainting):
excessive thirst (polydipsia):
blurry vision/pupillary inequality:

Any of the above eight symptoms provoked or worsened by:
heat exposure:
physical exertion:
heavy meals:
prolonged bedrest:
menses/periods:
drugs (especially blood pressure pills):

cold extremities (hands and feet):
disorientation/confusion:
hypertension (high blood pressure):
hypotension (low blood pressure):
variable blood pressure:
tinnitus (ringing in the ears):
shortness of breath:

Name: _____

Date: _____

headache:
muscle weakness:
fibromyalgia/chronic fatigue symptoms:
tremulousness/feeling of an internal tremor:
visual disturbances:

brain fog:
burnout, physical:
burnout, emotional:
decreased mental stamina:
depression:
difficulty finding the right word:
impaired concentration:
sleep disorders:
anxiety:

heart rhythm problems:
palpitations (feeling of an irregular heartbeat):
myocardial infarction/heart attack:
chest pain/discomfort:

feelings of chills:
feelings of fear:
flushing/getting red in the face:
getting pale in the face:
overheating:
nervousness:
overstimulation:
noise sensitivity:
light sensitivity:

abdominal pain or discomfort:
bloating/excessive feeling of full stomach:
constipation:
diarrhea:
nausea:
vomiting:
excessive urination/other bladder problems:

loss of hunger sensation:
loss of sex drive:

Name: _____

Date: _____

A prior diagnosis of a small-fiber peripheral neuropathy ("small-fiber neuropathy"):
Any sensory symptoms (numbness, tingling, or pain):

restless legs syndrome diagnosis or symptoms:

dry mouth/eyes?
feet pale or blue?
feet colder than rest of body?
sweating in feet less than in rest of body?
sweating in feet decreased or absent, e.g., after exercise or during hot weather?
sweating in hands increased over rest of body?
nausea, vomiting, or bloating after eating a small meal?
persistent diarrhea (> 3 loose BM's daily)?
persistent constipation (< 1 BM qod)?
urinary leaking?

Prior diagnosis of:
"chronic fatigue syndrome (CFS)"
"fibromyalgia syndrome (FMS)"
"interstitial cystitis (IC)"
"irritable bowel syndrome (IBS)"
"multiple chemical sensitivity syndrome (MCS)"
"idiopathic environmental intolerance syndrome (IEI)"
"chronic fatigue and immune dysfunction syndrome (CFIDS)"
"unrelenting fatigue (UF)"
"myalgic encephalomyelitis (ME)"

Diagnosis of rheumatological/arthritis disease:

Diagnosis of Ehlers-Danlos syndrome/other joint hypermobility disorder:

Known viral illness before symptoms started/changed (including COVID):

Closed head injury (CHI)/traumatic brain injury (TBI) history?

Date of last event of head trauma:
Total number of concussions:

FH amyloidosis or other neuropathy: no
unexplained weight loss: no
cardiac dysrhythmias: no
vitreous opacities: no
renal issues: no
cardiac hypertrophy: no

Name: _____

Date: _____

diarrhea: no
constipation: no
alternating diarrhea/constipation: no
ANS dysfunction, especially early on in the course: no
CTS, especially bilaterally: no

If dizziness is a prominent symptom for you, do you have any of the below symptoms when you are dizzy?

Vertigo/feeling of motion
Lightheadedness/feeling faint
Unsteadiness/imbalanced
Floating/wooziness/heavy-headedness

Nausea
Vomiting
Sweating
Ringing in your ears
Hearing loss
Weakness
Numbness
Double vision
Slurred speech
Swallowing problems
Gait issues, including favoring one side over another
Balance issues
Palpitations of your heart
Shortness of breath
Dry mouth
Chest pain
Feeling like you're going to pass out
Passing out
Objects in distance shimmering/wavy/appearing to move when not moving
Hyperventilation
Ear pain
Ear fullness
Drainage of fluid from the ear
Slow heart rate
Hearing your own voice echo in your ear

Is your headache, the head pain itself, associated with the dizziness, occurring before, during, or after your dizzy episodes? Yes No

Name: _____

Date: _____

If so, please describe a typical bout: _____

_____

_____

_____

Name: _____

Date: _____

| **How often do you experience increased pain or an unpleasant sensation on your skin during your most severe type of headache when you engage each of the following?** | **Does not apply to me** | **Never** | **Rarely** | **Less than half the time** | **Half the time or more** |
|---|---|---|---|---|---|
| | **Score: 0** | **Score: 0** | **Score: 0** | **Score: 1** | **Score: 2** |
| | | | | | |
| Combing your hair | | | | | |
| Pulling your hair back (e.g., ponytail) | | | | | |
| Shaving your face | | | | | |
| Wearing eyeglasses | | | | | |
| Wearing contac lenses | | | | | |
| Wearing earrings | | | | | |
| Wearing a necklace | | | | | |
| Wearing tight clothing | | | | | |
| Taking a shower (when shower water hits your face) | | | | | |
| Resting your face or head on a pillow | | | | | |
| Exposure to heat (e.g., cooking, washing your face with hot water) | | | | | |
| Exposure to cold (e.g., using an icepack, washing your face with cold water | | | | | |
| **Total score of each column** | | | | | |
| **Sum of total scores** | | | | | |

Name: _____

Date: _____

Instructions to patient: "Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then fill in the circle of the response to indicate how much you have been bothered by that problem **IN THE PAST MONTH.**" Please fill in ONE option only for each question."

| | Response | Not at all (1) | A little bit (2) | Moderately (3) | Quite a bit (4) | Extremely (5) |
|---|---|---|---|---|---|---|
| 1. | Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience from the past? | | | | | |
| 2. | Repeated, disturbing *dreams* of a stressful experience from the past? | | | | | |
| 3. | Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)? | | | | | |
| 4. | Feeling *very upset* when *something reminded* you of a stressful experience from the past? | | | | | |
| 5. | Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past? | | | | | |
| 6. | Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it? | | | | | |
| 7. | Avoid *activities* or *situations* because *they remind you* of a stressful experience from the past? | | | | | |
| 8. | Trouble *remembering important parts* of a stressful experience from the past? | | | | | |
| 9. | Loss of *interest in things that you used to enjoy?* | | | | | |
| 10. | Feeling *distant* or *cut off* from other people? | | | | | |
| 11. | Feeling *emotionally numb* or being unable to have loving feelings for those close to you? | | | | | |
| 12. | Feeling as if your *future* will somehow be *cut short*? | | | | | |
| 13. | Trouble *falling* or *staying asleep*? | | | | | |
| 14. | Feeling *irritable* or having *angry outbursts*? | | | | | |
| 15. | Having *difficulty concentrating*? | | | | | |
| 16. | Being *"super alert"* or watchful on guard? | | | | | |
| 17. | Feeling *jumpy* or easily startled? | | | | | |

Total Score ☐

Name: _____

Date: _____

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

Name: _____

Date: _____

| Over the last 2 weeks, how often have you been bothered by the following problems? | Not at all | Several Days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

**Total Score: = Add Columns** _____ + _____+ _____

= _____ **(total score)**

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

**Not at all** _____

**Somewhat difficult** _____

**Very difficult** _____

**Extremely Difficult** _____

Name: _____

Date: _____

**INSTRUCTIONS**

Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your healthcare professional.

1. On how many days in the last 3 months did you miss work or school because of your headaches?

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

Total (Questions 1-5) :

**What your Physician will need to know about your headache:**

1. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.)

2. On a scale of 0 - 10, on average how painful were these headaches? (where 0=no pain at all, and 10= pain as bad as it can be.)

Name: _____

Date: _____

Use the following scale to choose the most appropriate number for each situation:
0 = would *never* doze or sleep during that activity
1 = *slight* chance of dozing or sleeping during that activity
2 = *moderate* chance of dozing or sleeping during that activity
3 = *high* chance of dozing or sleeping during that activity

| **SITUATION** | **CHANCE OF SLEEPING** |
|---|---|
| Sitting and reading | ____ |
| Watching TV | ____ |
| Sitting inactive in a public place | ____ |
| Being a passenger in a motor vehicle for an hour or more | ____ |
| Lying down in the afternoon | ____ |
| Sitting and talking to someone | ____ |
| Sitting quietly after lunch (no alcohol) | ____ |
| Stopped for a few minutes in traffic while driving | ____ |
| **Total score (add the scores up)** | ____ |

Name: _____

Date: _____

| | | |
|---|---|---|
| Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)? | Yes | No |
| Do you often feel **T**IRED, fatigued, or sleepy during daytime? | Yes | No |
| Has anyone **O**BSERVED you stop breathing during your sleep? | Yes | No |
| Do you have or are you being treated for high blood **P**RESSURE? | Yes | No |
| | | |

| | | |
|---|---|---|
| **B**MI more than 35kg/m2? | Yes | No |
| **A**GE over 50 years old? | Yes | No |
| **N**ECK circumference > 16 inches (40cm)? | Yes | No |
| **G**ENDER: Male? | Yes | No |
| | | |

**TOTAL SCORE**

_____

Name: _____

Date: _____

| | Yes | No |
|---|---|---|
| I have pain all over my body | | |
| My pain is accompanied by a continuous and very unpleasant general fatigue | | |
| My pain feels like burns, electric shocks or cramps | | |
| My pain is accompanied by other unusual sensations throughout my body, such as pins and needles, tingling or numbness | | |
| My pain is accompanied by other health problems such as digestive problems, urinary problems, headaches or restless legs | | |
| My pain has a significant impact on my life, particularly on my sleep and my ability to concentrate, making me feel slower generally | | |

Name: _____

Date: _____

| MEDICATION | CURRENTLY TAKING? | EVER TAKEN? | WHEN/HOW LONG TAKEN | FREQUENCY OF DOSING | MAXIMUM DOSE | HELPFUL? | RATE HELPFULNESS: 1=MILD;2-MOD;3=MUCH | ANY SIDE EFFECTS? |
|---|---|---|---|---|---|---|---|---|
| ANTIDEPRESSANTS/PSYCHOACTIVE MEDICATIONS | | | | | | | | |
| Elavil (amitriptyline) | Yes No | Yes No | | | | YES NO | | |
| Pamelor (nortriptyline) | Yes No | Yes No | | | | YES NO | | |
| Vivactil (protriptyline) | Yes No | Yes No | | | | YES NO | | |
| Tofranil (imipramine) | Yes No | Yes No | | | | YES NO | | |
| Norpramin (desipramine) | Yes No | Yes No | | | | YES NO | | |
| Sinequan (doxepin) | Yes No | Yes No | | | | YES NO | | |
| Asendin (amoxapine) | Yes No | Yes No | | | | YES NO | | |
| Anafranil (clomipramine) | Yes No | Yes No | | | | YES NO | | |
| Desyrel (trazodone) | Yes No | Yes No | | | | YES NO | | |
| Nardil (phenelzine) | Yes No | Yes No | | | | YES NO | | |
| Parnate (tranylcypromine) | Yes No | Yes No | | | | YES NO | | |
| Eskalith (lithium) | Yes No | Yes No | | | | YES NO | | |
| Prozac (fluoxetine) | Yes No | Yes No | | | | YES NO | | |
| Zoloft (sertraline) | Yes No | Yes No | | | | YES NO | | |
| Paxil (paroxetine) | Yes No | Yes No | | | | YES NO | | |
| Celexa (citalopram) | Yes No | Yes No | | | | YES NO | | |
| Lexapro (escitalopram) | Yes No | Yes No | | | | YES NO | | |
| Effexor (venlafaxine) | Yes No | Yes No | | | | YES NO | | |
| Pristiq Idesvenlafaxine) | Yes No | Yes No | | | | YES NO | | |
| Cymbalta (duloxetine) | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Remeron (mirtazapine) | Yes No | Yes No | | | | YES NO | | |
| Luvox (fluvoxamine) | Yes No | Yes No | | | | YES NO | | |
| Buspar (buspirone) | Yes No | Yes No | | | | YES NO | | |
| Savella (milnacipran) | Yes No | Yes No | | | | YES NO | | |
| Serzone (nefazodone) | Yes No | Yes No | | | | YES NO | | |
| Viibryd vilazodone) | Yes No | Yes No | | | | YES NO | | |
| Wellbutrin (bupropion) | Yes No | Yes No | | | | YES NO | | |
| Silenor (doxepin) | Yes No | Yes No | | | | YES NO | | |
| Zelapor (sclegilene) | Yes No | Yes No | | | | YES NO | | |
| Abilify (aripiprazone) | Yes No | Yes No | | | | YES NO | | |
| Zyprexa (olanzapine) | Yes No | Yes No | | | | YES NO | | |
| Seroquel (quetiapine) | Yes No | Yes No | | | | YES NO | | |
| Risperdal (risperidone) | Yes No | Yes No | | | | YES NO | | |
| Geodon (ziprasodone) | Yes No | Yes No | | | | YES NO | | |
| Thorazine (chlorpromazine) | Yes No | Yes No | | | | YES NO | | |
| Inapsine (droperidol) | Yes No | Yes No | | | | YES NO | | |
| Haldol (haloperidol) | Yes No | Yes No | | | | YES NO | | |
| Mellaril (thioridazine) | Yes No | Yes No | | | | YES NO | | |
| Navane (thiothixene) | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| ANTICONVULSANTS/ANTISEIZURE MEDICATIONS | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Depakote (valproic acid/sodium valproate) | Yes No | Yes No | | | | YES NO | | |
| Neurontin/Gralise/Horizant (gabapentin) | Yes No | Yes No | | | | YES NO | | |
| Lyrica (pregabalin) | Yes No | Yes No | | | | YES NO | | |
| phenobarbital | Yes No | Yes No | | | | YES NO | | |
| Mysoline (primidone) | Yes No | Yes No | | | | YES NO | | |
| Dilantin (phenytoin) | Yes No | Yes No | | | | YES NO | | |
| Tegretol (carbamazepine) | Yes No | Yes No | | | | YES NO | | |
| Trileptal (oxcarbazepine) | Yes No | Yes No | | | | YES NO | | |
| Oxtellar (oxcarbazepine) | Yes No | Yes No | | | | YES NO | | |
| Aptiom (eslicarbazepine) | Yes No | Yes No | | | | YES NO | | |
| Topamax (topiramate) | Yes No | Yes No | | | | YES NO | | |
| Trokendi (topiramate) | Yes No | Yes No | | | | YES NO | | |
| Lamictal (lamotrigine) | Yes No | Yes No | | | | YES NO | | |
| Zonegran (zonisamide) | Yes No | Yes No | | | | YES NO | | |
| Gabitril (tiagabine) | Yes No | Yes No | | | | YES NO | | |
| Keppra (levetiracetam) | Yes No | Yes No | | | | YES NO | | |
| Briviact (brevitiracetam) | Yes No | Yes No | | | | YES NO | | |
| Potiga (ezogabine) | Yes No | Yes No | | | | YES NO | | |
| Banzel (rufinamide) | Yes No | Yes No | | | | YES NO | | |
| Fycompa (perampanel) | Yes No | Yes No | | | | YES NO | | |
| Vimpat (lacosamide) | Yes No | Yes No | | | | YES NO | | |
| Diamox (acetazolamide) or Zarontin (ethosuximide) | Yes No | Yes No | | | | YES NO | | |
| Potiga (ezogabine) | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| ANTIHYPERTENSIVES/BLOOD PRESSURE MEDICATIONS | Yes No | Yes No | | | | YES NO | | |
| Inderal (propranolol) | Yes No | Yes No | | | | YES NO | | |
| Corgard (nadolol) | Yes No | Yes No | | | | YES NO | | |
| Blocadren (timolol) | Yes No | Yes No | | | | YES NO | | |
| Toprol/Lopressor (metoprolol) | Yes No | Yes No | | | | YES NO | | |
| Tenormin (atenolol) | Yes No | Yes No | | | | YES NO | | |
| Calan/Verelan/Isoptin (verapamil) | Yes No | Yes No | | | | YES NO | | |
| Norvasc (amlodipine) | Yes No | Yes No | | | | YES NO | | |
| Procardia (nifedipine) | Yes No | Yes No | | | | YES NO | | |
| Cardizem (diltiazem) | Yes No | Yes No | | | | YES NO | | |
| Catapres (clonidine) | Yes No | Yes No | | | | YES NO | | |
| Benicar (olmesartan) | Yes No | Yes No | | | | YES NO | | |
| Atacand (candesartan) | Yes No | Yes No | | | | YES NO | | |
| Cozaar (losartan) | Yes No | Yes No | | | | YES NO | | |
| Plendil (felodipine) | Yes No | Yes No | | | | YES NO | | |
| Cardine (nicardipine) | Yes No | Yes No | | | | YES NO | | |
| Capoten (captopril) | Yes No | Yes No | | | | YES NO | | |
| Vasotec (enalapril) | Yes No | Yes No | | | | YES NO | | |
| Lotensin (benazepril) | Yes No | Yes No | | | | YES NO | | |
| lisinopril (Prinivil; Zestril) | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Yes No | Yes No | | | | YES NO | | |
| HORMONES | Yes No | Yes No | | | | YES NO | | |
| oral contraceptives (birth control pills) | Yes No | Yes No | | | | YES NO | | |
| estrogen | Yes No | Yes No | | | | YES NO | | |
| progesterone | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| SKELETAL MUSCLE RELAXANTS | Yes No | Yes No | | | | YES NO | | |
| Soma (carisoprodal) | Yes No | Yes No | | | | YES NO | | |
| Flexeril (cyclobenzaprine) | Yes No | Yes No | | | | YES NO | | |
| Amrix (cyclobenzaprie) | Yes No | Yes No | | | | YES NO | | |
| Robaxin (methocarbamol) | Yes No | Yes No | | | | YES NO | | |
| Zanaflex (tizanidine) | Yes No | Yes No | | | | YES NO | | |
| Lioresal (baclofen) | Yes No | Yes No | | | | YES NO | | |
| Norflex/Norgesic (orphenadrine) | Yes No | Yes No | | | | YES NO | | |
| Skelaxin (metaxalone) | Yes No | Yes No | | | | YES NO | | |
| Parafon Forte (chlorzoxazine) | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| ANXIOLYTICS/ANTI-ANXIETY MEDICATIONS | Yes No | Yes No | | | | YES NO | | |
| Valium (diazepam) | Yes No | Yes No | | | | YES NO | | |
| Ativan (lorazepam) | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Xanax (alprazolam) | Yes No | Yes No | | | | YES NO | | |
| Klonopin (clonazepam) | Yes No | Yes No | | | | YES NO | | |
| Librium (chlordiazepoxide) | Yes No | Yes No | | | | YES NO | | |
| Tranxene (clorzepate) | Yes No | Yes No | | | | YES NO | | |
| Restoril (temazepam) | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| SLEEP/ADD/ADHD MEDICATIONS | Yes No | Yes No | | | | YES NO | | |
| Provigil (modafinil) | Yes No | Yes No | | | | YES NO | | |
| Nuvigil (armodafanil) | Yes No | Yes No | | | | YES NO | | |
| Somnote (chloral hydrate) | Yes No | Yes No | | | | YES NO | | |
| Adderall (dextroamphetamine) | Yes No | Yes No | | | | YES NO | | |
| melatonin | Yes No | Yes No | | | | YES NO | | |
| Cylert (pemoline) | Yes No | Yes No | | | | YES NO | | |
| Rozerem (ramelteon) | Yes No | Yes No | | | | YES NO | | |
| Sonata (zaleplon) | Yes No | Yes No | | | | YES NO | | |
| Lunesta (eszopiclone) | Yes No | Yes No | | | | YES NO | | |
| Ambien (zolpidem) | Yes No | Yes No | | | | YES NO | | |
| Vyvanse (lisdexamfetamine) | Yes No | Yes No | | | | YES NO | | |
| Ritalin (methylphenidate) | Yes No | Yes No | | | | YES NO | | |
| Concerta (methylphenidate) | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| ALLERGY DRUGS (ANTIHISTAMINES/DECONGESTANTS/OTHER | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Zyrtec (ceterizine) | Yes No | Yes No | | | | YES NO | | |
| Claritin (loratadine) | Yes No | Yes No | | | | YES NO | | |
| Allegra (fexofenadine) | Yes No | Yes No | | | | YES NO | | |
| Sudafed (pseudoephedrine) | Yes No | Yes No | | | | YES NO | | |
| Benadryl (diphenhydramine) | Yes No | Yes No | | | | YES NO | | |
| Chlortrimeton (chlorpheniramine) | Yes No | Yes No | | | | YES NO | | |
| Periactin (cyproheptadine) | Yes No | Yes No | | | | YES NO | | |
| Dramamine (dimenhydrinate) | Yes No | Yes No | | | | YES NO | | |
| hydroxyzine (Vistaril; Atarax) | Yes No | Yes No | | | | YES NO | | |
| Antivert (meclizine) | Yes No | Yes No | | | | YES NO | | |
| Singulair (montelukast) | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| SUPPLEMENTS/HERBS/OTHER MEDICATIONS | Yes No | Yes No | | | | YES NO | | |
| Petadolex (butterbur) | Yes No | Yes No | | | | YES NO | | |
| Feverfew | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| riboflavin/vitamin B2 | Yes No | Yes No | | | | YES NO | | |
| magnesium | Yes No | Yes No | | | | YES NO | | |
| Coenzyme Q10 | Yes No | Yes No | | | | YES NO | | |
| fish oil | Yes No | Yes No | | | | YES NO | | |
| Vayacog | Yes No | Yes No | | | | YES NO | | |
| 5-hydroxytriptophan) | Yes No | Yes No | | | | YES NO | | |
| St. John's Wort | Yes No | Yes No | | | | YES NO | | |
| ginger | Yes No | Yes No | | | | YES NO | | |
| Migralief | Yes No | Yes No | | | | YES NO | | |
| oxygen | Yes No | Yes No | | | | YES NO | | |
| marijuana | Yes No | Yes No | | | | YES NO | | |
| Marinol | Yes No | Yes No | | | | YES NO | | |
| Azilect (rasagaline) | Yes No | Yes No | | | | YES NO | | |
| Methergine (methylergonovine) | Yes No | Yes No | | | | YES NO | | |
| Sansert (methysergide) | Yes No | Yes No | | | | YES NO | | |
| Namenda (memantine) | Yes No | Yes No | | | | YES NO | | |
| lidoderm patch | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| ACTIVITIES | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| acupuncture | Yes No | Yes No | | | | YES NO | | |
| chiropractic treatment/manipulation | Yes No | Yes No | | | | YES NO | | |
| dry needling | Yes No | Yes No | | | | YES NO | | |
| physical therapy | Yes No | Yes No | | | | YES NO | | |
| biofeedback | Yes No | Yes No | | | | YES NO | | |
| aromatherapy | Yes No | Yes No | | | | YES NO | | |
| essential oils | Yes No | Yes No | | | | YES NO | | |
| relaxation therapy | Yes No | Yes No | | | | YES NO | | |
| cognitive therapy | Yes No | Yes No | | | | YES NO | | |
| psychotherapy | Yes No | Yes No | | | | YES NO | | |
| relflexology | Yes No | Yes No | | | | YES NO | | |
| massage therapy | Yes No | Yes No | | | | YES NO | | |
| dietary changes | Yes No | Yes No | | | | YES NO | | |
| avoidance of triggering activities | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| PROCEDURES | Yes No | Yes No | | | | YES NO | | |
| Botox | Yes No | Yes No | | | | YES NO | | |
| trigger point injections | Yes No | Yes No | | | | YES NO | | |
| nerve blocks | Yes No | Yes No | | | | YES NO | | |
| sphenopalatine ganglion blocks (SPG blocks) | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| DEVICES | Yes No | Yes No | | | | YES NO | | |
| Cefaly | Yes No | Yes No | | | | YES NO | | |
| Cerena | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| TRIPTANS | Yes No | Yes No | | | | YES NO | | |
| Imitrex injectable (sumatriptan) | Yes No | Yes No | | | | YES NO | | |
| Sumavel (needleless sumatriptan) | Yes No | Yes No | | | | YES NO | | |
| Alsuma | Yes No | Yes No | | | | YES NO | | |
| Zecuity (sumatriptan patch) | Yes No | Yes No | | | | YES NO | | |
| Onzetra Xsail (sumatriptan powder) | Yes No | Yes No | | | | YES NO | | |
| Imitrex nasal spray | Yes No | Yes No | | | | YES NO | | |
| Treximet (sumatriptan + naprosyn) | Yes No | Yes No | | | | YES NO | | |
| Imitrex pills (25, 50, 100 mg) (sumatriptan) | Yes No | Yes No | | | | YES NO | | |
| Maxalt ZMT (5, 10 mg) (rizatriptan) | Yes No | Yes No | | | | YES NO | | |
| Maxalt tabs (5, 10 mg) (rizatriptan) | Yes No | Yes No | | | | YES NO | | |
| Zomig tabs (2.5, 5 mg) (zolmitriptan) | Yes No | Yes No | | | | YES NO | | |
| Zomig ZMT (2.5, 5 mg) (zolmitriptan) | Yes No | Yes No | | | | YES NO | | |
| Zomig nasal spray | Yes No | Yes No | | | | YES NO | | |
| Relpax (eletriptan) | Yes No | Yes No | | | | YES NO | | |
| Axert (almotriptan) | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Amerge (naratriptan) | Yes No | Yes No | | | | YES NO | | |
| Frova (frovatriptan) | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| ERGOTS | Yes No | Yes No | | | | YES NO | | |
| Cafergot pills (ergotamine) | Yes No | Yes No | | | | YES NO | | |
| Cafergot suppositories (ergotamine) | Yes No | Yes No | | | | YES NO | | |
| Migranal (DHE) nasal spray | Yes No | Yes No | | | | YES NO | | |
| DHE injectable | Yes No | Yes No | | | | YES NO | | |
| Levadex (DHE inhaler) | Yes No | Yes No | | | | YES NO | | |
| Bellergal (belladonna - ergotamine - phenobarbital) | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| NSAIDsCOX-II inhibitors | Yes No | Yes No | | | | YES NO | | |
| ibuprofen (Motrin, Advil) | Yes No | Yes No | | | | YES NO | | |
| naproxen (Naprosyn, Aleve) | Yes No | Yes No | | | | YES NO | | |
| diclofenac (Voltaren, Cataflam, Cambia, Zipsor) | Yes No | Yes No | | | | YES NO | | |
| Orudis (ketoprofen) | Yes No | Yes No | | | | YES NO | | |
| Clinoril (sulindac) | Yes No | Yes No | | | | YES NO | | |
| Indocin (iindomethacin) | Yes No | Yes No | | | | YES NO | | |
| Relafen (nabumetone) | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Feldene (piroxicam) | Yes No | Yes No | | | | YES NO | | |
| Nalfon | Yes No | Yes No | | | | YES NO | | |
| Dolobid (diflunisal) | Yes No | Yes No | | | | YES NO | | |
| Ansaid (flurbiprofen) | Yes No | Yes No | | | | YES NO | | |
| Daypro (oxaprozin) | Yes No | Yes No | | | | YES NO | | |
| Etodolac | Yes No | Yes No | | | | YES NO | | |
| Arthrotec | Yes No | Yes No | | | | YES NO | | |
| Toradol (ketorolac): shots, pills, nasal spray (Sprix) | Yes No | Yes No | | | | YES NO | | |
| Vioxx (rofecoxib) | Yes No | Yes No | | | | YES NO | | |
| Celebrex (celecoxib) | Yes No | Yes No | | | | YES NO | | |
| Bextra (valdecoxib) | Yes No | Yes No | | | | YES NO | | |
| Mobic (meloxicam) | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| SALICYLATES (ASPIRIN)/TYLENOL/COMBINATIONS | Yes No | Yes No | | | | YES NO | | |
| aspirin | Yes No | Yes No | | | | YES NO | | |
| Tylenol (acetaminophen) | Yes No | Yes No | | | | YES NO | | |
| Midrin/Epidrin (isometheptene/dichloralphenazone/Tylenol) | Yes No | Yes No | | | | YES NO | | |
| Tylenol/aspirin/caffeine (Excedrin; Anacin; Midol; Goody | Yes No | Yes No | | | | YES NO | | |
| Powders; Vanquish; BC powders) | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ANTIEMETICS/ANTI NAUSEA/VOMITING | Yes No | Yes No | | | | YES NO | | |
| Tigan (trimethobenzamide) tabs/suppositories | Yes No | Yes No | | | | YES NO | | |
| Reglan (metoclopramide) | Yes No | Yes No | | | | YES NO | | |
| Phenergan (promethazine) tabs/suppositories | Yes No | Yes No | | | | YES NO | | |
| Compazine (prochlorperazine) tabs/suppositories | Yes No | Yes No | | | | YES NO | | |
| Zofran (tabs; ODT) | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| BUTALBITAL COMBINATIONS | Yes No | Yes No | | | | YES NO | | |
| Fioricet (with Tylenol and caffeine); can have codeine | Yes No | Yes No | | | | YES NO | | |
| Fiorinal (with aspirin and caffeine); can have codeine | Yes No | Yes No | | | | YES NO | | |
| Phrenilin (butalbital/Tylenol) | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| STEROIDS | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| lidocaine nasal spray/drops | Yes No | Yes No | | | | YES NO | | |
| | Yes No | Yes No | | | | YES NO | | |
| NARCOTICS | Yes No | Yes No | | | | YES NO | | |
| Fentora (fentanyl oral dissolving tablets) | Yes No | Yes No | | | | YES NO | | |
| Duragesic (fentanyl patch) | Yes No | Yes No | | | | YES NO | | |
| hydrocodone (Lortab; Vicodin; Lorcet; Norco; Vicoprofen; Zydone) | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Tylenol #3 or Tylenol # 4 (codeine) | Yes No | Yes No | | | | YES NO | | |
| Darvon (propoxyphene); Darvocet (propoxyphene + Tylenol) | Yes No | Yes No | | | | YES NO | | |
| oxycodone (Oxycontin; Oxy IR; Percocet) | Yes No | Yes No | | | | YES NO | | |
| Demerol (meperidine) | Yes No | Yes No | | | | YES NO | | |
| Stadol nasal spray (butorphanol) | Yes No | Yes No | | | | YES NO | | |
| Nubain (nalbuphine) | Yes No | Yes No | | | | YES NO | | |
| Actiq (fentanyl dissolving) | Yes No | Yes No | | | | YES NO | | |
| Talwin (pentazocine) | Yes No | Yes No | | | | YES NO | | |
| Dilaudid (hydromorphone) | Yes No | Yes No | | | | YES NO | | |
| Butrans (buprenorphine) | Yes No | Yes No | | | | YES NO | | |
| Nucynta (tapentadol) | Yes No | Yes No | | | | YES NO | | |
| Opana (oxymorphone) | Yes No | Yes No | | | | YES NO | | |
| methadone | Yes No | Yes No | | | | YES NO | | |
| | | Yes No | | | | YES NO | | |
| Ultram (tramadol) | Yes No | Yes No | | | | YES NO | | |
| Ultracet (tramadol + Tylenol) | Yes No | Yes No | | | | YES NO | | |

Name: _____

Date: _____

| **CGRP antagonists, injectables** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Aimovig (erenumab) (monthly) | Yes | No | Yes | No | | | Yes | No |
| Ajovy (fremanezumab) (monthly or quarterly) | Yes | No | Yes | No | | | Yes | No |
| Emgality (galcanezumab) (monthly) | Yes | No | Yes | No | | | Yes | No |
| Vyepti (eptinezumab) (quarterly, IV) | Yes | No | Yes | No | | | Yes | No |
| | | | | | | | | |
| **CGRP-R antagonists, oral (gepants)** | | | | | | | | |
| Ubrelvy (ubrogepant) (acute therapy only) | Yes | No | Yes | No | | | Yes | No |
| Nurtec ODT (rimegepant) (acute and QOD prevention) | Yes | No | Yes | No | | | Yes | No |
| Qulipta (atogepant) (prevention only) | Yes | No | Yes | No | | | Yes | No |
| | | | | | | | | |
| **Ditans (5HT-1F antagonists)** | | | | | | | | |
| Reyvow (lasmiditan) | Yes | No | Yes | No | | | Yes | No |