Tanya R. Bilchik, MD
Board Certified in Headache Medicine
Board Certified in Neurology
Denise M. McGrath, APRN
Gretchen Michaelson, APRN
The MS Clinic at HHC

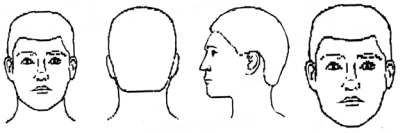
The Hartford Headache Center, LLC
144 Main Street, East Hartford, 06118 tel 860-895-3133 fax 860-895-3131
www.hartfordheadache.com

Name _____ **Date** _____

■ On what part of the head do the headaches start?

❑ right side ❑ left side ❑ either side ❑ both sides
❑ back ❑ on top ❑ temples ❑ behind/around eyes
❑ forehead ❑ face ❑ neck ❑ other _____

Use these diagrams to shade areas of pain:



■ How long ago did the current headaches start? _____ weeks _____ months _____ years

■ How old were you when any headache started? _____

■ How long does the headache usually last? ____ minutes ____ hours ____ days ❑ constant

■ How often does the headache occur? ____ x/day ____ x/week ____ x/month ____ x/year ❑ constant

■ Does the headache awaken you from sleep..... ❑ yes ❑ no

■ Is the headache getting: ❑ more severe ❑ more frequent ❑ both

■ After the headache starts, does it usually: ❑ stay in one place ❑ move around explain_____

_____

■ Describe the pain: ❑ throbbing/pulsating ❑ pressing/squeezing ❑ stabbing ❑ sharp ❑ dull/nagging ❑ exploding
❑ other (explain)_____

SLIGHT < 1 2 3 4 5 6 7 8 9 10 > WORST IMAGINABLE

■ Circle degree of pain ***when headaches start:*** < 1 2 3 4 5 6 7 8 9 10 >

■ Circle degree of pain with ***most of your headaches***: < 1 2 3 4 5 6 7 8 9 10 >

■ Circle degree of pain with ***your worst headache***: < 1 2 3 4 5 6 7 8 9 10 >

■ Do any blood relatives have severe headaches? ..... ❑ yes ❑ no

If yes, who/diagnosis _____

■ Do you have any history of head or neck injury? ..... ❑ yes ❑ No
If yes, did injury involve a loss of consciousness? ❑ yes ❑ no

■ Which of the following makes the headache better? ❑ rest ❑ activity ❑ darkness ❑ quiet ❑ hot compress
❑ pregnancy ❑ menopause ❑ cold compress ❑ scalp or temple pressure

YOUR LIFESTYLE

■ Are you: ❑ single ❑ married ❑ separated ❑ divorced ❑ widowed

■ Do you exercise regularly? ❑ yes ❑ no If yes, what exercise/how often? _____

■ Do you regularly skip meals? ❑ yes ❑ no

■ How much caffeine do you consume in a day? (coffee, tea, soda, chocolate, etc) _____

■ Cigarettes - # days _____/# years _____; Alcohol - oz/day _____

■ Do you have any problems sleeping? ..... ❑ yes ❑ no

■ Do you wake feeling rested? ..... ❑ yes ❑ no

■ Other drug use: ..... ❑ yes ❑ no

■ Are you exposed to: ❑ fumes ❑ dust ❑ solvents ❑ airborne particles

Associated Headache Symptoms

■ **Are any of the following symptoms associated with the headache?**
Indicate by marking ***B*** (before), ***X*** (during), or ***A*** (after)

__ Spots before eyes - type
__ blindness (R) (L)
__ blurring (R) (L)
__ eyelid droop (R) (L)
__ can see only half of objects
__ tearing (R) (L)
__ double vision
__ eye redness (R) (L)
__ eyes puffy (R) (L)
__ light sensitivity
__ noise sensitivity
__ odor sensitivity
__ nose blocked/discharge (R) (L)

__ nausea
__ vomiting
__ stomach cramps
__ hunger
__ loss of apetite
__ diarrhea

Face/scalp

__ pale
__ redness
__ sweating
__ tender
__ pain on chewing
__ puffy
__ decreased jaw opening

Neck

__ stiff
__ tender

__ depression
__ fatigue
__ anxiety
__ irritability
__ dificulty concentrating
__ difficulty understanding
__ difficulty talking *(finding words)*
__ fainting *(feel like or have fainted)*
__ slurred speach
__ dizzy *(lightheaded • unsteady • spinning)*

Hands and/or feet

__ cold
__ pale
__ sweaty
__ mottled

Weakness (W); numbness (N); both (B)

__ face (R) (L)
__ arms (R) (L)
__ legs (R) (L)
__ arm & leg (R) (L)
__ numbness around lips

■ **Indicate if any of the following factors *BROUGHT ON/TRIGGERED* (+) or *WORSENED* (++) your headache**

__ sleep; too much/too little
__ sexual activity
__ chocolate
__ medications *(list below)*
__ emotional stress; during/after
__ missed meal
__ citrus fruits
__ menstrual period
__ depression/anxiety
__ change in weather
__ cheeses
__ pregnancy
__ physical activity
__ seasons
__ MSG
__ menopause
__ erect position
__ alcohol
__ other foods *(list below)*
__ oral contraceptives
__ bending over
__ processed meats
__ straining/coughing

list foods or medications if indicated above: _____

_____

_____

The Hartford Headache Center, LLC • 114 Main Street, East Hartford, CT 06118
Tanya R. Bilchik, MD • Denise M. McGrath, APRN • Gretchen Michaelson, APRN