EASTERN RADIOLOGISTS
INTERVENTIONAL RADIOLOGY

2090-A W Arlington Blvd, Greenville, NC 27834
Mon–Fri 7:45am–4pm
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Patient Name _____ DOB ___ /___ /___ Date ___ /___ /___ MRN _____

CONSULT: HEADACHE

What brought you to our clinic: _____

_____

HEADACHE HISTORY

Age of onset _____ When did headaches become a problem? _____

Was there a trigger for your current headache problem?

- ☐ Specific Stress
- ☐ Injury
- ☐ Motor vehicle accident
- ☐ Illness
- ☐ Menarche or pregnancy or birth control pills or hormone replacement
- ☐ Other (please specify) _____

HEADACHE CHARACTERISTICS (circle all that apply)

How often do you have headaches? _____ Are they increasing in frequency YES NO

Onset of headaches: Gradual Suddenly Varies

Duration of Headaches: Minutes Hours Days

Do your headaches prevent you from doing: Activities School Work Household chores?

Location of headaches: Left side Right side Both/other _____
Forehead Temple Behind eyes Back of head Neck

Pain Type: Pressure Stabbing Throbbing Tight band
Burning Dull ache other _____

What brings on your headaches or triggers your headaches? (circle all that apply)

Food Hunger Fatigue Stress Menstruation
Coughing Odors Too Much Caffeine Alcohol Wine
Too Little Sleep Sexual Activity Bright Lights/Sun After Stress (first day of vacation, weekend, etc)
Prolonged Computer Work Weather Changes Loud Sounds

Pre-headache symptoms: (circle all that apply)

Mood changes Personality changes Change in appetite Food cravings
Neck pain Fatigue None other _____

Aura Symptoms: (circle all that apply)

Bright lights/flashes of lights/multi-colored lights Zigzag lines Paralysis Numbness/tingling
Dizziness/vertigo Partial loss of vision/blurry vision/blindness Upset stomach/nausea none

Symptoms during headaches:

Nausea/upset stomach Vomiting Bright lights/sun bothers you Numbness or tingling
Eye tears Odors bother you Difficulty concentrating Nose symptoms
Loud sounds bother you Dizziness/lightheadedness/vertigo Increased sensitivity of scalp/hair/ears
Mood changes Irritability

Alleviating factors:

Lying down/sleeping Being in dark room Keeping physically active Pacing back-and-forth
Massage Cold pack Hot pack

HEADACHE-RELATED DISABILITY:

How many days of work or school have you missed in past year because of headache? _____

Number of doctors visits for headache in past year?
Primary Care Provider _____ Emergency department _____ Walk-in Clinics _____

What is your ability to function during headaches? Normal Slightly decreased Severely decreased Totally bedridden

HEADACHE-RELATED INVESTIGATIONS (CIRCLE ALL THAT APPLY)

Previous testing: CT scans MRI EEG Sinus X-ray Neck X-ray Other

Previous consultations:
Neurologist Pain Clinic ENT Specialist Eye Doctor Dentist
Internal Medicine Psychiatrist Therapist Allergy Specialist

HEADACHE SPECIFIC TREATMENTS

Multi-disciplinary health care and headache purchases:
Chiropractor Psychologist Nutritionist Acupuncturist
Naturopath/homeopath/herbalist Physiotherapist Massage Therapist
Aromatherapy Hot packs Cold packs Eye masks
Self-help books Mouth guard Herbs/supplements Other _____

Current headache medications (please list with doses, prescription and over the counter AND as needed medications):

_____

_____

_____

_____

Previous headache medications that you are no longer taking (prescription and over the counter):

_____

_____

_____

_____

How long does it take to become pain-free after taking medication?
< 1 hour 1-2 hours >2 hours I never become pain-free after medication

Has your pain or its treatment disrupted your relationship with family or friends? YES NO
If yes, describe _____

What other medical conditions do you have (circle all that apply)?
High Blood pressure Heart Disease Diabetes Blood disorder Lung disorder
Kidney disorder Liver disorder Anxiety Depression Other _____

What surgeries have you had?

_____

_____

_____

_____

FAMILY HISTORY:

Any other family members with headaches or similar health conditions? Who/what?

SOCIAL HISTORY:

Marital Status:

Married Single Separated Divorced Widowed

Do you have children? YES NO

Do you drive? YES NO

Work status:

Working Not working Retired Disabled Veteran Homemaker Student

Occupation _____

Do you drink caffeinated beverages? YES NO

How many per day? _____

Alcohol use:

Never Rare Frequent Occasionally Alcohol dependant Recovered alcoholic

Drinks per week _____

Tobacco use:

Cigarettes _____ per day

Cigars _____ per day

Smokeless tobacco_____ per day

I quit smoking on (date): _____