UFHealth
UNIVERSITY OF FLORIDA HEALTH

Department of Neurology Headache Clinic

New Patient Intake Form

Date: _____

Name: _____ Date of Birth: _____

Primary Care Physician: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____ Email: _____

Referring Physician (if different from PCP): _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Past Medical History

1. Have you had any of the following problems?

☐ Heart Disease
☐ High Blood Pressure
☐ Diabetes
☐ Stroke
☐ Seizures
☐ Head Injury
☐ Ear, nose, and throat problems
☐ Dental Problems/TMJ
☐ Arthritis
☐ Neck Spine Problems
☐ Skin Problems
☐ Liver disease
☐ Blood Clots
☐ Thyroid Disease
☐ Lung Disease
☐ Cancer
Type: _____
☐ Asthma
☐ Kidney Problems
☐ Depression
☐ Bipolar Disease
☐ Lupus
☐ Migraine
☐ GERD/Reflux
☐ Fibromyalgia
☐ Irritable Bowel Disease

Others: _____

2. Have you had any of the following surgeries/procedures?

☐ Heart Surgery/Bypass Graft
☐ Heart Stent
☐ Cancer
☐ Colon polyp
☐ C-Section
☐ Gall Bladder
☐ Appendix
☐ Breast Lump
☐ Tonsils
☐ Hysterectomy
☐ GI Bypass
☐ Hernia
☐ Brain
☐ Bladder
☐ Hip replacement
☐ Knee Replacement
☐ Cataract

Others: _____

3. **Allergies**
Please list any allergy to medication and/or food

Medication/Food/Substance	**Reaction**

4. **Current Medications**
Please list all your medications, including vitamins and herbal supplements that you regularly take

Medication	**Dose**	**Frequency**

Social History

Occupation: _____ Marital Status: _____ Number of children: _____
Highest Level of Education: _____
Handedness (circle one): Right Left
Do you smoke? _____
Do you drink alcohol?_____
Do you use recreational drugs?_____

Do you exercise regularly? (circle one) Yes No How frequently?_____

Females: Are you, or could you be pregnant? (circle one) Yes No

Family History

Do you know of any blood relative who has had any of the following conditions?

☐ Brain Tumor Relative(s): _____
☐ Migraine Relative(s): _____
☐ Seizures Relative(s): _____
☐ Dementia Relative(s): _____
☐ Brain Tumor Relative(s): _____
☐ High Blood Press. Relative(s): _____
☐ Heart Disease Relative(s): _____
☐ Stroke Relative(s): _____
☐ Cancer Relative(s): _____
☐ Diabetes Relative(s): _____
☐ Thyroid Disease Relative(s): _____

Others: _____

UF Headache clinic follow up visit
REVIEW OF SYSTEMS

UF Health Neuromedicine
Hospital, 1st floor 1505 SW
Archer Rd, Gainesville, FL 2608

Name_____

Date _____

Please indicate any symptom or condition that you have experienced **in the past 2 weeks**:

☐ No symptoms

Generall
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Malaise/Fatigue
- ☐ Excessive sweating

Eyes
- ☐ Blurred vision
- ☐ Double Vision
- ☐ Photophobia
- ☐ Eye pain
- ☐ Eye discharge
- ☐ Eye redness

GI
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stools
- ☐ Melena

Endo/Heme/Allergy
- ☐ Easy bruise/bleed
- ☐ Environmental allergies
- ☐ Increased thirst

Skin
- ☐ Rash
- ☐ Itching

Cardio
- ☐ Chest pain
- ☐ Palpitations
- ☐ Orthopnea
- ☐ Claudication
- ☐ Leg swelling
- ☐ PND

GU
- ☐ Pain in urination
- ☐ Urgency
- ☐ Frequency
- ☐ Blood in urine
- ☐ Flank pain

Neurological
- ☐ Dizziness
- ☐ Headaches
- ☐ Tingling
- ☐ Tremor
- ☐ Sensory change
- ☐ Speech change
- ☐ Focal weakness
- ☐ Weakness
- ☐ Seizures
- ☐ Loss of consciousness

HENT
- ☐ Tinnitus
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Congestion
- ☐ Sinus pain
- ☐ Stridor
- ☐ Sore throat

Respiratory
- ☐ Cough
- ☐ Hemoptysis
- ☐ Sputum production
- ☐ Shortness of breath
- ☐ Wheezing

Musculosk
- ☐ Muscle pain
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain
- ☐ Falls

Psychiatric
- ☐ Depression
- ☐ Suicidal ideations
- ☐ Substance abuse
- ☐ Hallucinations
- ☐ Nervous/anxious
- ☐ Insomnia
- ☐ Memory loss

Other Symptom(s): _____

Headache History

1. How old were you when your headaches started?_____

2. Do you have more than one type of headache? ☐Yes ☐ No

Please answer the following questions thinking about <u>your most troublesome headaches</u>

1. Frequency
   a. <u>Over the past month</u>,
      - How many times did you experience a headache? _____
      - How many days did your headache completely stop your activity? _____

   b. <u>Over the past 3 months</u>,
      - How many times you have you gone to the emergency room for headaches? _____
      - How many missed days of work or school due to headaches? _____

2. How bad is the headache on a scale of 0 to 10: where 0 is no pain and 10 is the worst headache of your life?
   Low ____ to High ____ Average Intensity: ____

   Headache Disability During Attack
   ☐ Normal Activity
   ☐ Slight decrease in function
   ☐ Moderate decrease in function
   ☐ Severe decrease in function
   ☐ Confined to a bed

3. Location of Pain (Check all that apply)
   ☐ Temple ☐ Eye
   ☐ Back of the head ☐ Ear
   ☐ Side of the head ☐ neck
   ☐ Front of the head ☐ Jaw
   ☐ Around the head ☐ Other: _____

4. Sidedness
   ☐ Right-sided **<u>Change Sides?</u>**
   ☐ Left-sided ☐ Between Attacks
   ☐ Both sides ☐ During Attacks
   ☐ Varies ☐ Both between and during attacks

5. Pain Characteristics (Check all that apply)
   ☐ Throbbing ☐ Pressure ☐ Pulsating
   ☐ Achy ☐ Burning ☐ Pounding
   ☐ Tight ☐ Sharp ☐ Splitting
   ☐ Dull ☐ Shooting ☐ Heavy
   ☐ Stabbing ☐ Sore ☐ Other: _____

6. How long each headache attack lasts?
   With medication: Lasts ____ minutes ____ hours ____ days
   Without medication: Lasts ____ minutes ____ hours ____ days

7. Do you experience any of these symptoms before the headache starts?
   Check all that apply

☐ Blurry vision	☐ Dizziness	☐ Numbness/tingling
☐ Flashing lights	☐ Vertigo	☐ Unable to speak
☐ ZigZag lines	☐ Lightheadedness	☐ Unable to concentrate
☐ Loss of vision	☐ General weakness	☐ Other: _____
☐ Tunnel Vision	☐ One side weakness	

8. Pattern of Headache (Check all that apply)
   Time of Day: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Awakens from sleep

   Are they most frequent:

☐ Weekends	☐ Weekdays	☐Vacation	☐ Seasonal
☐ Spring	☐ Summer	☐ Fall	☐ Winter

9. Associated Symptoms (Check all that apply)

☐ Nausea	☐ Increased urination	☐Heaviness/weakness in one extremity
☐ Vomiting	☐ Sore/Stiff Neck	☐ Dizziness
☐ Sensitive to:	☐ Ringing in the ears	☐ Lightheadedness
☐ Light	☐ Blurred vision	
☐ Sound	☐ Anxiety	
☐ Odors	☐ Irritability	
☐ Diarrhea	☐ Decreased Concentration	
☐ Constipation	☐ Memory Problems	
☐ Trouble Sleeping	☐ Confusion	

☐ Eye-Tearing	☐ Eyelid Drooping	☐ Decreased Pupil Size
☐ Right	☐ Right	☐ Right
☐ Left	☐ Left	☐ Left
☐ Both sides	☐ Both sides	☐ Both sides

☐ Nose Congestion	☐ Flushing
☐ Right	☐ Right
☐ Left	☐ Left
☐ Both sides	☐ Both sides

10. Triggers (Check all that apply)

☐ Fasting	☐ Talking	☐ Pregnancy
☐ Chocolate	☐ Chewing	☐ Stress
☐ Too much caffeine	☐ Exercise	☐ Weather Changes
☐ Too little caffeine	☐ Shaving	☐ Allergies
☐ MSG	☐ Sexual Intercourse	☐ Altitude
☐ Wine	☐ Before Menstrual Period	☐ Sunlight
☐ Coughing	☐ During Menstrual Period	☐ Lack of sleep
☐ Alcohol beverages	☐ After Menstrual Period	☐ Too much sleep

11. Relieving Factors (Check all that apply)

☐ Lying down	☐ Massage
☐ Hot compress	☐ Keeping active
☐ Cold Compress	☐ Standing
☐ Dark quiet room	☐ Other: _____

MEDICATION LIST
(CIRCLE THOSE YOU HAVE BEEN ON)

BETA BLOCKERS
Atenolol (e.g. Tenormin)
Metoprolol (e.g. Lopressor)
Nadolol (e.g. Corgard)
Propranolol (e.g. Inderal)
Timolol (Timoptic)
Bisoprolol (Zebeta)

CALCIUM CHANNEL BLOCKERS
Amlodipine (e.g. Norvasc)
Diltiazem (e.g. Cardizem)
Nifedipine (e.g. Procardia)
Verapamil (e.g. Calan)

ANTIDEPRESSANTS
Amitriptyline (e.g. Elavil)
Desipramine (e.g. Norpramin)
Doxepin
Imipramine
Nortriptyline (e.g. Pamelor)
Trazodone
Mirtazapine (e.g. Remeron)
Venlafaxine (e.g. Effexor)
Duloxetine (Cymbalta)

MAO INHIBITORS
Isocarboxazid (e.g. Marplan)
Phenelzine (e.g. Nardil)
Tranylcypromine (e.g. Parnate)

ERGOTS
Dihydroergotamine (e.g. DHE)
Methylergonovine (e.g. Methergine)
Nasal Dihydroergotamine (e.g. Migranal)
Ergotamine/Caffeine (e.g. Cafergot)

NSAIDS
Celecoxib (e.g. Celebrex)
Aspirin
Diclofenac (e.g. Voltaren, Cambia)
Etodolac (e.g. Lodine)
Indomethacin (e.g. Indocin)
Ketoprofen (e.g. Orudis)
Ketorolac (e.g. Toradol)
Naproxen Sodium (e.g. Naprosyn, Aleve)
Ibuprofen (Advil)

TRIPTANS
Almotriptan (e.g. Axert)
Eletriptan (Relpax)
Frovatriptan (e.g. Frova)
Naratriptan (e.g. Amerge)
Rizatriptan (e.g. Maxalt)
Sumatriptan (e.g. Imitrex)
Zolmitriptan (e.g. Zomig)

SEROTONIN ANTAGONISTS
Cyproheptadine (e.g. Periactin)

ANTICONVULSANTS
Carbamazepine (e.g. Tegretol)
Oxcarbazepine (Trileptal)
Diphenylhydantoin (e.g. Dilantin)
Divalproex sodium (e.g. Depakote)
Gabapentin (e.g. Neurontin)
Levetiracetam (e.g. Keppra)
Phenobarbital
Lamotrigine (e.g. Lamictal)
Topiramate (e.g. Topamax)
Zonisamide (e.g. Zonegran)

ACE INHIBITORS
Captopril (e.g. Capoten)
Enalapril (e.g. Vasotec)
Lisinopril (e.g. Zestril)
Candesartan (e.g. Atacand)
Losartan (Cozaar)

ALPHA-ADRENERGIC BLOCKERS
Clonidine (e.g. Catapres)
Doxazosin (e.g. Cardura)

STEROIDS
Dexamethasone (e.g. Decadron)
Prednisone
Methylprednisolone (e.g. Medrol)

MEDICATION LIST (Continued)
(CIRCLE THOSE YOU HAVE BEEN ON)

STIMULANTS/ANTI MANIC
Dextroamphetamine (e.g. Dexedrine)
Lithium (e.g. Lithobid)
Methylphenidate (e.g. Ritalin)

ANTIPSYCHOTIC
Quetiapine (e.g. Seroquel)
Risperidone (e.g. Risperdal)

BENZODIAZEPINES/ TRANQUILIZERS
Alprazolam (e.g. Xanax)
Buspirone (e.g. Buspar)
Clonazepam (e.g. Klonopin)
Lorazepam (e.g. Ativan)
Zolpidem (e.g. Ambien)
Diazepam (e.g. Valium)

MUSCLE RELAXANTS
Baclofen (e.g. Lioresal)
Carisoprodol (e.g. Soma)
Cyclobenzaprine (e.g. Flexeril)
Orphenadrine (e.g. Norflex)
Tizanidine (e.g. Zanaflex)
Methocarbamol (e.g. Robaxin)

HORMONES
Estrogen/progesterone (e.g. many OCPs)
Estrogen (e.g. Premarin)
Medroxyprogesterone (e.g. Provera)

ANALGESICS & OTCs
Butalbital/Acetaminophen/Caffeine (e.g. Fioricet)
Butalbital/Aspirin/Caffeine (e.g. Fiorinal)
Isometheptene/Dichloralphenazone/Acetaminophen (e.g. Midrin)
Acetaminophen (e.g. Tylenol)
Acetaminophen/Aspirin/Caffeine (e.g. Excedrin Migraine)
Acetaminophen/Caffeine (e.g. Excedrin Tension)
Aspirin/Caffeine (e.g. BC Powder)
Decongestant (e.g. Sudafed)

NARCOTICS/ OPIOIDS
Butorphanol (e.g. Stadol)
Fentanyl (e.g. Duragesic)
Codeine (e.g. Fioricet with codeine)
Meperidine (e.g. Demerol)
Long acting oxycodone (e.g. Oxycontin)
Oxycodone (e.g. Percocet)
Tramadol (e.g. Ultram)
Hydromorphone (e.g. Dilaudid)
Hydrocodone/Acetaminophen (e.g. Norco)

DIURETICS
Acetazolamide (e.g. Diamox)
Furosemide (e.g. Lasix)

ANTINAUSEA
Meclizine (e.g. Antivert)
Metoclopramide (e.g. Reglan)
Prochlorperazine (e.g. Compazine)
Promethazine (e.g. Phenergan)
Ondansetron (e.g. Zofran)

TOXINS
OnabotulinumtoxinA (e.g. Botox)

SUPPLEMENTS
CoQ 10
Vitamin B 2 (e.g. Riboflavin)
Feverfew
Magnesium
Migra-Lieve
Melatonin
Butterbur

MIDAS Questionnaire

	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 (Question 1-5)

0-5 -Grade I; 6-10 – Grade II; 11-20- Grade III; 21+ Grade IV

	Never (6 points each)	**Rarely** (8 points each)	**Sometimes** (10 points each)	**Very Often** (11 points each)	**Always** (13 points each)
1. When you have headaches, how often is the pain severe?					
2. How often do you limit your ability to do usual daily activities including household work, school, work, or social activities?					
3. When you have a headache, how often do you wish you could lie down?					
4. In the past 4 weeks, how often you felt tired to do work or daily activities because of your headaches?					
5. In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?					
6. In the past 4 weeks, how often did headaches limit the ability to concentrate on work or daily activities?					
Total: **Score range 36-78;** **Score 50+ severe impact**					

The information on this form is accurate to the best of my knowledge:

_____ _____

Patient Signature Date completed

UF Headache clinic follow up visit
Review of systems

University of Florida Health
Neurology
2000 SW Archer Road 3rd Floor
Gainesville, FL 32610

Name_____

Date _____

Please indicate any symptom or condition that you have experienced **in the past 2 weeks**:

GENERAL HEALTH	EYES	EARS/NOSE/THROAT	RESPIRATORY
☐ Weight Loss	☐ Blurry Vision	☐ Hearing Loss	☐ Shortness of Breath
☐ Weight Gain	☐ Eye Pain	☐ Nose Bleeds	☐ Frequent Cough
☐ Fever/Chills	☐ Double Vision	☐ Sore throat	☐ Coughing up blood
☐ Chills	☐ Light Sensitivity	☐ Sinusitis	☐ Asthma
☐ Fatigue	☐ Dry Eyes	☐ Trouble Swallowing	☐ COPD
	☐ Teary Eyes	☐ Ringing in the ear	

CARDIOVASCULAR	ENDOCRINE	GASTROINTESTINAL	GENITO-URINARY
☐ Chest Pain	☐ Increased Thirst	☐ Nausea and/or Vomiting	☐ Pain on urination
☐ Palpitations	☐ Cold Intolerance	☐ Diarrhea	☐ Kidney Stones
☐ Fainting	☐ Heat Intolerance	☐ Constipation	☐ Trouble Holding Urine
☐ Swollen legs	☐ Osteoporosis	☐ Abdominal pain	☐ Trouble Starting Urine
☐ Ankle Swelling		☐ Gastritis	☐ Irregular Periods

MUSCULOSKELETAL	HAIR/SKIN	MENTAL HEALTH	NEUROLOGIC
☐ Joint Pain	☐ Hair Loss	☐ Depression	☐ Headaches
☐ Pain in the limbs	☐ Rash	☐ Anxiety	☐ Tremors
☐ Muscle Pain	☐ Itching	☐ Trouble Sleeping	☐ Numbness/Tingling
☐ Joint Inflammation	☐ Nail Problems	☐ Memory Loss	☐ Dizziness
☐ Back Pain		☐ Confusion	☐ One sided weakness
☐ Neck Pain			☐ Involuntary Movements
			☐ Balance problems
			☐ Shakiness

Other Symptoms:

_____