NEUROLOGY GROUP OF BERGEN COUNTY, P.A.

Headache History Form

NAME: _____ **DATE:** _____

Please answer the following questions. When answering the following questions, if you don't remember the exact number of headache days, please give the best answer you can. If a headache lasted more than one day, count each day.

1. Do you have more than 15 headaches per month? Yes ____ No ____
2. In the last month (past 30 days) on how many days did you have a headache of any type?___
3. In the last month (past 30 days) on how many days did you have no headache at all? _____
4. Do your headaches last four (4) hours or longer (untreated)? Yes ____ No ____
5. How long have you had migraines? _____months _____years
6. Have you failed two or more prophylactic prescribed headache medications? Yes __No____
   If yes, please circle any medications you have tried or are currently taking.

Antidepressants	**Antiepileptics/ Anticonvulsants**	**Beta-blockers**	**Calcium Channel Blockers**	**Angiotensin-Converting Enzyme (ACE) Inhibitors/ Angiotensin II Receptor Blockers (ARB)**
Amitriptyline/Elavil	Divalproex sodium/ Depakote	Atenolol/Tenormin	Diltiazem/Cardizem	Candesartan/Atacand
Citalopram/Celexa	Gabapentin/Neurontin	Metoprolol/Toprol	Nifedipine/Procardia	Enalapril/Vasotec
Doxepin/Prudoxin	Topiramate/Topamax	Nadolol/Corgard	Nimodipine/Nymalize	Irbesartan/Avapro
Fluoxetine/Prozac	Valproic Acid	Propranolol/Inderal	Verapamil/Covera	Lisinopril, Zestril
Fluvoxamine/Luvox		Timolol/Blocadren		Losartan/Cozaar
Mirtazapine/Remeron				Olmesartan/Benicar
Nortriptyline/Pamelor				Ramipril/Altace
Paroxetine/Paxil				Valsartan/Diovan
Escitalopram/Lexapro				
Sertraline/Zoloft				
Venlafaxine/Effexor				

OTHER: _____

Do you ever experience/Are your headaches associated with: (check all that apply)

- ☐ Moderate or severe pain intensity
- ☐ Nausea
- ☐ Vomiting
- ☐ Sensitivity to light/sound
- ☐ Occurs on one side
- ☐ Pulsating
- ☐ Missed days at work or school
- ☐ Emergency Room visits
- ☐ Worse with head movement, activity
- ☐ Made better with triptan medications

Please list: _____

- ☐ Family history of migraine headaches?

Please list: _____

If you are unclear about the medications you have tried contact your pharmacy. Your pharmacy should be able to provide you a list of all of the medications prescribed to you.