Synergycentre
Dental & Healthcare

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HEADACHE/MIGRAINE HISTORY & ASSESSMENT FORM - Patient Form

In addition, please bring a current list of your medications.

PERSONAL HISTORY

Date: _____

Last Name: _____ First Name: _____

Date of Birth: D _____M _____YR _____ **Age**: _____ Height _____ Weight _____ Sex: M / F / Other

OHIP (health card) #: _____ **Version Code:** _____

Address: _____ City/Town:_____ Postal Code: _____

Telephone: (_____) _____ Cell: (_____) _____ Work: (_____) _____

Preference of which number to call you: *(please circle)* HOME / CELL / WORK May we leave a voicemail? YES / NO

***Email:** _____ Occupation: _____

How did you hear about us? (*please circle)*

Friend or Family Facebook/Instagram Website Advertisement Physician/Healthcare Professional

Signage on building/Driving by Email Google Search Other: _____

Do you have a private / extended healthcare plan? Y / N Name of provider: _____

MEDICAL HISTORY

Family Physician: _____ Address: _____

Are you currently **pregnant or breastfeeding**? **Y / N** Are you planning a **pregnancy** within the next year? **Y / N**

Major illnesses or Surgeries [PAST or PRESENT] (cancer, diabetes, surgery, etc.): _____

_____

Do you have any **upcoming/planned procedures/surgeries? Y / N** _____

Do you have any **neurological** conditions? [i.e. myasthenia gravis, multiple sclerosis, ALS, Lambert-Eaton syndrome, Bells Palsy, etc.] **Y / N**

Current health conditions/diagnoses (please include *everything*, even if you may feel it is not relevant/significant): _____

_____

_____

Please list any **current medications** including vitamins, herbal supplements (include dosage if able): _____

_____

_____

Are you taking **blood thinners** [anti-coagulant or anti-platelet medications]? **Y / N** If yes, please explain: _____

Please list any **Allergies** [foods, medication, environmental, other]: _____

Do you smoke? **Y / N** How much/often? _____

Have you ever used botox before? **Y / N** How so? (please circle): Medically Cosmetically

You may NOT have Botox if you are pregnant, breastfeeding, or during the first three months following delivery.

HEADACHE HISTORY

(Please note: Any type of headache counts during the following questions, not just the ones you may consider "migraines". Days when headaches were successfully treated with migraine-specific acute medications (e.g. triptans) are also considered headache days.)

Onset:

At what age did the headaches start? Age: _____ How long have you suffered with headaches? _____

Frequency of headaches:

In the last month (past 30 days), on how many days did you have a headache? _____

In the last 3 months (past 90 days), on how many days did you have a headache? _____

If you cannot recall how many headache days you have had, try counting the number of **headache-FREE days to help you determine.

Duration of headaches:

How long do your headaches usually last? (please circle) Minutes Hours Days

If you chose hours or days, **how many hours at a time** do your headaches usually last? _____ hours

Symptoms/features of headaches (past 30 days): (please circle)

Sensitive to light (felt more comfortable in a dark place)?	Never	Rarely	Less than half the time	More than half the time
Sensitive to sound (felt more comfortable in a quiet place)?	Never	Rarely	Less than half the time	More than half the time
How often was the pain moderate to severe?	Never	Rarely	Less than half the time	More than half the time
How often did you feel nauseated/sick to your stomach?	Never	Rarely	Less than half the time	More than half the time

Please circle any other symptoms you have experienced:

Vomiting One-side of head only Both sides of head

Front of head/back of head Pulsating/throbbing

Sharp/stabbing Pressure/Squeezing Tension

Inability to work/function Other: _____

Presence of Aura? **Y / N** *(Aura: sensory disturbances can include: flashes of light, blind spots, vision changes or tingling in your hand/face).*

During headaches, do you experience any pain in other areas/muscles? (jaw, eyes, ears, neck, shoulder, etc) **Y / N** If so, please explain:

_____

Aggravating factors/triggers: (circle all that apply)

Physical activity Mental exertion/concentration Computer use/eye strain Stress Sleep depravation Driving

Trauma Dehydration Diet (*chocolate / alcohol / caffeine / cheese / spices or flavourings*) Other: _____

Medication use (past 30 days):

How many days did you use over-the-counter medications to treat your headache attacks? _____

How many days did you use prescription medications to treat your headache attacks? _____

Impact of headaches on activities or making plans (past 30 days):

How many days did you miss school or work because of your headaches? _____

How many days did you miss of leisure activities because of your headaches? _____

How often do headaches limit your ability to do usual daily activities including household chores/work?
Never Rarely Less than half the time More than half the time

How often did your headaches interfere with making plans? Never Rarely Less than half the time More than half the time

Previous diagnostic investigations: (please circle)

Have you had any of the following investigations/tests completed in the past year? CT Scan MRI Sleep test/study
Ophthalmological testing

Emergency room visits related to headaches? # of visits _____

In your own words:

How do headaches/migraines affect your daily life (work, school, activities, family, etc)?

_____

_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in comparison to feeling just tired?

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of dozing (0 = low, 3 = high)
Sitting and reading	
Watching TV	
Sitting still in a public place (e.g. a theatre, a cinema or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when the circumstances allow	
Sitting and talking to someone	
Sitting quietly after lunch without having drunk alcohol	
In a car or bus while stopped for a few minutes in traffic	
TOTAL	

PHQ9 **Over the last <u>two weeks</u> how often have you been bothered by the following problems?**		**0** Not at all	**1** Several Days	**2** More than half the days	**3** Nearly every day
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or staying asleep, sleeping too much	☐	☐	☐	☐
D	Feeling tired or having little energy	☐	☐	☐	☐
E	Poor appetite or overeating	☐	☐	☐	☐
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H	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	☐	☐	☐	☐
I	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	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

GAD7 **Over the last <u>two weeks</u> how often have you been bothered by the following problems?**	**0** Not at all	**1** Several Days	**2** Over than half the days	**3** Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score (add your column scores)				
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

<u>*PLEASE SIGN*</u> - AUTHORIZATION OF INFORMATION

I have carefully read all <u>5</u> pages of this document *(including the Medication page appended)* and confirm that the above/below stated/written information and disclosure of my personal health information is correct to the best of my knowledge.

Patient Signature: _____

Print Name: _____

Thank you for trusting us with your care,

Dr. Maria Tetelbaum & Team

****Please circle any of the following medications that you have tried for your headaches.****

Prophylactic Examples

Antidepressants	Antiepileptics/ Anticonvulsants	Beta-blockers	Calcium Channel Blockers	Angiotensin-Converting Enzyme (ACE) Inhibitors/ Angiotensin II Receptor Blockers (ARB)
Amitriptyline	Divalproex sodium	Atenolol	Diltiazem	Candesartan
Citalopram	Gabapentin	Metoprolol	Nifedipine	Enalapril
Doxepin	Topiramate	Nadolol	Nimodipine	Irbesartan
Fluoxetine	Valproic acid	Propranolol	Verapamil	Lisinopril
Fluvoxamine		Timolol		Losartan
Mirtazapine				Olmesartan
Nortriptyline				Ramipril
Paroxetine				Valsartan
Protriptyline				
Sertraline				
Venlafaxine				

Acute/Abortive Examples

NSAIDs/ Analgesics	Ergot Alkaloid Derivative	Triptans	Combination/Other
Acetaminophen	Ergotamine	Almotriptan	Acetaminophen/aspirin/caffeine
Aspirin	Dihydroergotamine (DHE)	Eletriptan	Butalbital/acetaminophen/caffeine
Diclofenac		Frovatriptan	Butalbital/aspirin/caffeine
Ibuprofen		Naratriptan	Butorphanol
Naproxen		Rizatriptan	Ergotamine/caffeine
		Sumatriptan	Sumatriptan/naproxen
		Zolmitriptan	

Other previous treatments attempted/used previously?: (please circle) Botox Occipital nerve block Opioids

Other: _____

****The physician will be asking you about the OUTCOME of each medication you have taken. (Effective, intolerant, failed, sub-optimal, contraindicated).**