UCLA HEADACHE RESEARCH AND TREATMENT PROGRAM

NEW PATIENT INFORMATION FORM

Date: _____

First Name: _____

Last Name: _____

Age: _____

At what age did your headaches begin? _____

How frequent are your headaches? _____ Times Per_____ ☐ Continuous

How long do your headaches last? _____ (Number) _____

What is the location of your pain? (check all that apply)

☐ Left Side ☐ Right Side ☐ Behind the eye ☐ Forehead ☐ Temple

☐ Top of Head ☐ Back of Head ☐ Neck

What is the severity of the pain? (check all that apply) What is ☐ Mild ☐ Moderate ☐ Severe

the quality of the pain? ☐ Pressure ☐ Constant ☐ Stabbing ☐ Pulsing

Do you have any of the following symptoms associated with your headaches?

☐ Nausea ☐ Sensitivity to Light ☐ Sensitivity to Sound ☐ Sensitivity to smell ☐ Sensitivity to touch

☐ Dizziness ☐ Fatigue ☐ Difficulty concentrating ☐ Yawning ☐ Redness or tearing of one or both eyes

☐ Runny nose

Do you ever have any of the following before or during your headache?

☐ Change in your vision ☐ Numbness or tingling in face or arm ☐ Difficulty speaking ☐ Weakness of face, arm, or leg

Is your headache made worse by movement? ☐ Yes ☐ No

Is your headache worse with any of the following? ☐ Standing up ☐ Lying down ☐ Bending Over

Do any of the following trigger your headaches?

☐ Skipped Meals ☐ Alcohol ☐ Weather change ☐ Menstrual Period ☐ Air travel ☐ Altitude change

Other (Please enter)_____

Does anyone in your family have headaches?

☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Son ☐ Daughter

Other (Please enter)_____

Do any of the following conditions run in your family? ☐ Seizure(epilepsy) ☐ Stroke ☐ Heart disease

Have you ever had significant head trauma with loss of consciousness? ☐ Yes ☐ No

Do any of the following trigger your headaches? (Stress, Altitude, Flying or Heat) ☐ Yes ☐ No

How much caffeine do you consume? _____ Cups of coffee/tea or caffeinated sodas per day

How much alcohol do you consume? _____ Drinks per day

Do you smoke? ☐ Yes ☐ No

Do you have difficulty falling asleep? ☐ Yes ☐ No

Do you have difficulty sleeping through the night? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Please list any other significant medical problems that you have:

1.
2.
3.
4.
5.
6.

Please list any medications you are presently taking:

Name of the Medication	Dosage	Frequency

Please check any of the following medications that you have tried in the past to treat your headaches:

- ☐ Imitrex (Sumatriptan)
- ☐ Maxalt (Rizatriptan)
- ☐ Zomig(Zolmitriptan)
- ☐ Amerge (Naratriptan)
- ☐ Relpax (Eletriptan)
- ☐ Frova (Frovatriptan)
- ☐ Axert (Almotriptan)
- ☐ Methergine(methylergonovine)
- ☐ Migranal (Dihydroergotamine Spray)

- ☐ Advil (Ibuprofen)
- ☐ Aleve (Naproxen)
- ☐ Cambia (Diclofenac)
- ☐ Indocin (Indomethacin)
- ☐ Toradol (Ketorolac)
- ☐ Relafen (Nabumetone)
- ☐ Celebrex (Celecoxib)
- ☐ Excedrin
- ☐ Vicodin
- ☐ Fiorinal/Fioricet

- ☐ Toprol or Lopressor (Metoprolol)
- ☐ Inderal (Propranolol)
- ☐ Tenormin (Atenenolol)
- ☐ Atacand (Candesartan)
- ☐ Aldactone (Spironolactone)
- ☐ Microzide (Hydrochlorothiazide)
- ☐ Calan (Verapamil)
- ☐ Norvasc (Amlodipine)

- ☐ Elavil (Amitriptyline)
- ☐ Pamelor (Nortriptyline)
- ☐ Topamax (Topiramate)
- ☐ Depakote (Divalproex Sodium)
- ☐ Keppra (Levetiracetam)
- ☐ Trileptal (Oxcarbazepine)
- ☐ Tegretol (Carbamazepine)
- ☐ Cymbalta (Duloxetine)
- ☐ Effexor (Venlafaxine)
- ☐ Wellbutrin (Buproprion)
- ☐ Savella (Milnacipran)
- ☐ Lamictal (Lamotrigine)
- ☐ Zonegran (Zonisamide)

- ☐ Neurontin (Gabapentin)
- ☐ Namenda (Memantine)
- ☐ Lyrica (Pregabalin)
- ☐ Decadron (Dexamethasone)
- ☐ Medrol (Methylprednisolone)
- ☐ Deltasone (Prednisone)

Other:_____

Which of these medications was effective? _____

Did any of these medications have side effects? _____

Do you have any of the following symptoms?

- ☐ Fevers
- ☐ Joint pain
- ☐ Skin rash
- ☐ Nausea
- ☐ Abdominal Bloating
- ☐ Chest pain
- ☐ Difficulty with urination
- ☐ Double vision
- ☐ Difficulty with balance
- ☐ Weakness of arms or legs
- ☐ Numbness
- ☐ Feeling depressed
- ☐ Hypoglycemia
- ☐ Joint swelling
- ☐ Itching
- ☐ Abdominal pain
- ☐ Heart palpitations
- ☐ Sexual dysfunction
- ☐ Blurred vision
- ☐ Dizziness
- ☐ Tremor
- ☐ Tingling
- ☐ Feeling anxious
- ☐ Fatigue
- ☐ Neck pain
- ☐ Raynaud's Phenomenon
- ☐ Constipation
- ☐ Rapid heartbeat
- ☐ Trouble with memory
- ☐ Weight loss or gain
- ☐ Back pain
- ☐ Diarrhea

PLEASE DESCRIBE ANYTHING ELSE YOU WOULD LIKE US TO KNOW:

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The Migraine Disability Assessment Test

The **MIDAS** (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS:
Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your healthcare professional.

_____ 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 (Questions 1-5)

_____ A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.)

_____ B. On a scale of 0 - 10, on average how painful were these headaches? (where 0=no pain at all, and 10= pain as bad as it can be.)

Scoring: After you have filled out this questionnaire, add the total number of days from questions 1-5 (ignore A and B).

MIDAS Grade	Definition	MIDAS Score
I.	Little or no disability	0-5
II.	Mild disability	6-10
III.	Moderate disability	11-20
IV.	Severe disability	21+

Please give the completed form to your clinician.

This survey was developed by Richard B. Lipton, MD, Professor of Neurology, Albert Einstein College of Medicine, New York, NY, and Walter F. Stewart, MPH, PhD, Associate Professor of Epidemiology, Johns Hopkins University, Baltimore, MD.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ **+** _____ **+** _____ **+** _____

=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**
☐	☐	☐	☐

GAD-7

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)