MEDICATION HISTORY FORM

Please highlight or circle medications you have tried. Please indicate if they worked (W), didn't work (DW) or if there were any side effects (SE).

Over the Counter

Aspirin
Aleve
Excedrin Migraine
Anacin
Acetaminophen (Tylenol)
Aspirin Free Excedrin
Ibuprofen (Motrin, Advil, etc.)

Herbal/Vitamin

Feverfew
Vitamin B2 (riboflavin)
Petadolex (butterbur)
Magnesium Oxide
Deplin
Gliacin

Prescription Pain Medications

Naproxen Sodium (Anaprox, Naprelan, Naprosyn)
Fioricet/ Esgic (Butalbital, Acetaminophen, Caffeine)
Fiorinal (Aspirin/Butalbital/Caffeine)
Fiorinal with Codeine/Fioricet with Codeine/Fiorinal #3
Panlor Acetaminophen/Caffeine/Dihydrocodeine)
Phrenilin (Butalbital/Acetaminophen)
Percocet, Percodan, Tylox (Oxycodone)
OxyContin
Vicodin, Vicoprofen, Lorcet (Hydrocodone), Norco
Zohydro
Morphine IV/IM MS Contin, Avinza
Kadian
Lidoderm Patch
Butrans
Methadone (Dolophine)
Tylenol #3 or #4
Fentora
Demerol (Meperidine)
Toradol (Ketorolac) Tabs, injections
Stadol Nasal Spray
Sprix Nasal Spray
Ultram (Tramadol) /Ultracet
Nucynta

Headache Medications

Imitrex (Sumatriptan) tablets, Nasal Spray & Injections, Patch
Maxalt (Rizatriptan) tablet or MLT (dissolves)
Zomig (Zolmitriptan) or ZMT (dissolves), Nasal Spray
Prodrin (Similernea)
Midrin (isomethep/dichloralphen/acet.)
Axert (Almotriptan)
Treximet
Amerge (Naratriptan)
Relpax
Migranal Nasal Spray
DHE IV, IM
Frova
Alsuma
Ergomar SL
Sumavel Dose Pro
Cambia
Cafergot Tab, supp., Cafergot PB supp.

Anti Inflammatory

Voltaren (Diclofenac sodium)
Arthrotec
Celebrex (Celecoxib)
Mobic (Meloxicam)
Indocin (Indomethacin)
Zorvolex
Tvorbex

Blood Pressure

Inderal (Propranolol)
Bystolic
Losartan
Metoprolol (Lopressor, Toprol XL)
Nadolol (Corgard)
Benicar
Atenolol (Tenormin)
Verapamil (Calan, Covera HS)
Atacand(Candesartan)

Anti-Depressant Medications

Vivactil (Protriptyline)
Prozac (Fluoxetine)
Pristiq
Elavil (Amitriptyline)
Wellbutrin (Buproprion)
Paxil (Paroxetine)
Pamelor (Nortriptyline, Aventyl)
Viibryd
Remeron (Mirtazapine)
Doxepin (Sinequan)
Zoloft (Sertaline)
Trazodone (Desyrel)
Desipramine (Norpramin)
Cymbalta
Effexor (Veniafaxine)
Celexa
Fetzima
Brintellix
Lexapro (Escitalopran)

Anti-Seizure Medications

Topamax (Topiramate) Trokendi XR		Gabapentin, Gralise(Neurontin)
Zonegran	Gabitril	Keppra
Trileptal (Oxcarbamezaapine)	Depakote	Oxtellar XR

Mood Stabilizer

Lithium (Eskalith, Lithobid)	Lamictal (Lamotrigine)	Seroquel (Quetiapine), XR
Rexulti		

Muscle Relaxers Medications

Skelaxin (Metaxalone)	Flexeril (Cyclobenzaprine)	Soma (Carisoprodol)
Zanaflex (Tizanidine)	Parafon Forte (Chlorzoxazone)	Norflex
Robaxin		Baclofen

Anti Nausea Medications

Compazine (Prochloperazine)	Phenergan (Promethazine)	Zofran (Ondansetron)
Reglan (Metoclopramide	Tigan (Trimethobenzamide)	

Anxiety

Xanax (Alprazolam)	Ativan (Lorazepam)	Buspar (Buspirone)
Diazepam (Valium)	Klonopin (Clonazepam)	

Corticosteroids

Medrol Prednisone Decadron Solumedrol PO, IV

Other Medications or Treatment:

Botulinum Toxin (Botox) Trigger Point Shot

ADD / ADHD

Dexedrine	Intuniv	Adderall	Adderall XR	Concerta
Vyvanse	Ritalin	Focalin	Focalin XR	

Fibromyaligia

Lyrica Savella

Sleep Medications

Ambien Rozerem Lunesta Belsomra Silenor

Miscellaneous

Namenda Low-Dose Naltrexone

Emergency Room

What medications worked in the emergency room?

What medications didn't work in the emergency room?

Headache Intake Assessment Form

Name: ____ Date: ____________________

Age: _____________ Sex: M F Marital Status: ______________________________________

Name of Spouse: ____

Name(s) and Age(s) of Children: ____

____

Names and Types of Pets: ____

Education: ____

Occupation: ________________________________ Spouse's Occupation: _____________________

Does anyone in your family have headaches, or have they had moderate-to-severe headaches in the past?

If yes, please specify. ____

How old were you when you started having headaches? ____________________________________

How often do you have a mild-moderate headache? ______________________________________

How often do you have a severe headache/migraine? ____________________________________

How long do the severe headaches last? ____ hours ____ one day ____ two days ____ three or more days

On a scale of one to ten, with ten being the worst, how severe are the headaches?

1 2 3 4 5 6 7 8 9 10

Mild **Moderate** **Severe**

Do you have some type of headache every day? ____

How much do these daily headaches bother you? Mildly ______ Moderately ______ Severely ______

Where does the pain occur for your daily headaches? ______________________________________

Where does the pain occur for your severe headaches/migraines? ______________________________

What does your headache typically feel like? (please circle one)

Throbbing/pulsing *Pressing/squeezing* *Sharp/stabbing* *Dull/achy*

Does your eye tear on the side of the headache? Yes No

Are the headaches much worse in the last few months? Yes No

Are the headaches much worse in the last year? Yes No

Do you frequently have nausea with your headaches? Yes No

Do you typically have visual problems with your headaches Yes No

such as flashing lights, sprinkles of light or vision loss on one side?

Do you typically experience sensitivity to light? Yes No

Do you typically experience sensitivity to sound? Yes No

Are your headaches worse before or during you menstrual cycle? Yes No

Do you take any birth control pill or hormone? Yes No

Circle the following if these play a role in your Headaches or in producing an occasional headache:

stress	exercise
after stress is over	exertion
weather changes	missing a meal
foods	cigarette odor
bright sunlight	perfume odors
sexual activity	**different seasons:**
under sleeping	summer
oversleeping	fall
hormonal changes	winter
menstrual cycle	spring

Do you have very cold feet and hands in winter? Yes No

Have you had any of the following tests?

CT scan for your headaches? Y or N If so, when? ________________________ Results ____________________________

MRI for the headaches? Y or N If so, when? ________________________ Results ____________________________

Blood tests in the past year? ____________________________________ Were they normal? ______________________________________

Have you tried Biofeedback or relaxation training for headaches? Yes No

If yes, has it helped? ____

____

How much do you exercise and what do you do? ____

____

Which doctors have you seen for headaches, if any? ____

____

____

Which family doctors or other doctors do you see? ____

____

____

Do you smoke cigarettes? Yes No *If yes,* how many? ________________________________

Do you drink alcohol? Never Occasionally Daily

Have you had any type of problem with addictive drugs in the past? ____

Do you tend to be anxious or nervous? Yes No

If yes, is your anxiety mild, moderate or severe? ____

Do you have a history of depression? Yes No

If yes, when was your last episode? ______________ *Is/was it: Mild Moderate or Severe*

Do you have trouble sleeping? Yes No

If yes, do you have trouble going to sleep or staying asleep? ____

Other past medical history:

Operations? ____

____

Ulcers or stomach problems? ____

____

Asthma? ____

____

Any other medical problems? ____

____

____

____

Side effects or allergies to any medications? ____

____

____

What medications are you **currently** taking? ____

____

____

____

STRESS FORM

Robbins Headache Clinic

Name: ____ **Date:**_____________________________

How did you hear abut the practice? ____

If referred, name and phone number of referring physician: ____

Do you have any siblings? Names and ages (if applicable)

Describe briefly (personality traits, medical problems, etc.):

Father: ____

Mother: ____

List several traits that best describe your personality: ____

History of clinical/counseling intervention: Yes No

If yes, was it *Inpatient* or *Outpatient* (circle one**) Dates:** _______**Currently ongoing:** Yes No

Primary therapist was/is: (circle one) Psychiatrist Marriage Counselor Psychologist Social Worker

Other (*Please describe)* ____

Primary reason for seeing the above: ____

(Turn page over)

The current areas in which I am under stress include the following: (circle all that apply)

Work

Marriage

School

Financial Pressure

Time Management

Relationship/Interactions w/ parents

Relationship/Interactions w/ children

None of the above

Other (please list below)

Please elaborate briefly on any items checked above: ____

____

Please note if any of the following apply to you: you may elaborate briefly on any that apply

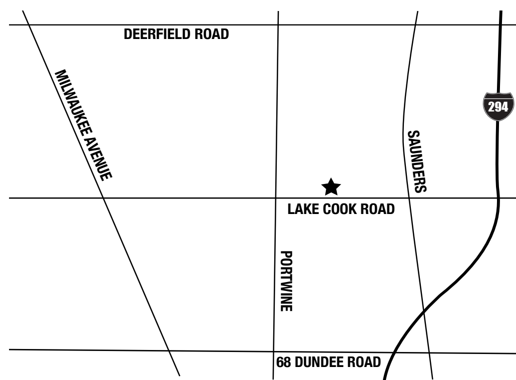
History of alcoholism in family ____

Emotional abuse as a child ____

Early or recent head injury ____

Suicidal thoughts (past or present) ____

Friends and family members do not understand or appreciate the nature of your headaches:



Robbins Headache Clinic
2610 Lake Cook Road, Suite 160
Riverwoods, IL 60015

Directions to Robbins Headache Clinic

Located on the North side of Lake Cook Road in the "Podolsky Circle" building, about 1/2 mile West of I-294 and about 1 mile East of Milwaukee Ave., next to the Holiday Inn Express.

Our Phone: 847-374-9399

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 concentration 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
	☐	☐	☐

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