MEDICATION & NON-MEDICATION HISTORY FORM Rev.9-22-20

Name:_____

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

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

Herbal/Vitamin

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

Prescription Pain Medications

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

Headache Medications

Imitrex (Sumatriptan) tablets, Nasal Spray & Injections (Sumavel, Zembrace)
Maxalt (Rizatriptan) tablet or MLT (dissolves)
Zomig (Zolmitriptan) or ZMT (dissolves), Nasal Spray
Ubrelvy (Ubrogepant)
Midrin (isomethep/dichloralphen/acet.)
Prodrin (isomethetpene/caffeine/acet.)

Amerge (Naratriptan)	Onzentra Xsail, Tosymra NS		Cambia
Axert (Almotriptan)	Relpax (eletriptan)		Migranal Nasal Spray
Frova (frovatriptan)	Treximet	Ergomar	DHE IV, IM
	Reyvow		Nurtec

Anti Inflammatory

Arthrotec	Indocin (Indomethacin)	Voltaren (Diclofenac sodium)
Celebrex (Celecoxib)	Mobic (Meloxicam)	Other _____

Blood Pressure

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

Anti-Depressant Medications

Desipramine (Norpramin)	Celexa (Citalopram)	Brintellix or Trintellix	Remeron (Mirtazapine)
Doxepin	Lexapro (Escitalopram)	Cymbalta (Duloxetine)	Trazodone (Desyrel)
Elavil (Amitriptyline)	Paxil (Paroxetine)	Deplin	Wellbutrin (Bupropion)
Pamelor (Nortriptyline)	Prozac (Fluoxetine)	Effexor (Venlafaxine)	MAO inhibitors (Emsam, Nardil)
Vivactil (Protriptyline)	Viibryd	Fetzima	Other_____
	Zoloft (Sertaline)	Pristiq (Desvenlafaxine)	

CGRP

Aimovig	Vyepti	Ajovy	Emgality

Anti-Seizure Medications

Depakote (divalproex sodium)
Gabapentin, Gralise (Neurontin)
Gabitril
Keppra
Trileptal, Oxtellar XR (oxcarbazepine)
Topamax (Topiramate) Trokendi XR, Qudexy
Trileptal (Oxcarbamezaapine)
Zonegran (Zonisamide)
Other _____

Mood Stabilizer

Lamictal (Lamotrigine)
Lithium (Eskalith, Lithobid)
Rexulti
Saphris
Abilify (aripiprazole)
Seroquel (Quetiapine), XR
Zyprexa
Vraylar

Muscle Relaxer Medications

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

Anti Nausea Medications

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

Anxiety

Ativan (Lorazepam)
Buspar (Buspirone)
Vistaril (Hydroxyzine)
Diazepam (Valium)
Klonopin (Clonazepam)
Xanax (Alprazolam)
Other _____

Corticosteroids

Decadron Medrol Prednisone

Other Medications or Treatment

Botulinum Toxin (Botox) Trigger Point Injection SPG Block

ADD / ADHD

Adderall Adderall XR Concerta Dexedrine Focalin Focalin XR Intuniv Ritalin Vyvanse

Fibromyaligia

Lyrica Savella

Sleep Medications

Ambien Belsomra Lunesta Rozerem Silenor
OTC's Other _____ Melatonin

Miscellaneous

Low-Dose Naltrexone (LDN) Namenda Nuvigil Provigil

GI

Amitiza Symproic Movantik Linzess Trulance

Outside of Medication - Please Indicate If It Helped(Y) or (N)

Physical Therapy
Psychotherapy
Meditation
Acupuncture
Biofeedback
Massage
Miscellaneous

Emergency Room

What medications worked in the emergency room?

What medications didn't work in the emergency room?

Headache Intake Assessment Form **Rev. 3-10-20**

Name: _____ Date of Birth _____ 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 a history of headaches or migraines?

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? ____ hour(s) ____ 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 mild-moderate 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 have nausea with your migraines?	Yes	No	
Do you typically have visual problems with your headaches such as flashing lights, sprinkles of light or vision loss on one side?	Yes	No	
Do you experience sensitivity to light?	Yes	No	
Do you experience sensitivity to sound?	Yes	No	
Are your headaches worse before or during you menstrual cycle?	Yes	No	N/A
Do you take any birth control pills or hormones?	Yes	No	N/A

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

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

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

Do you get motion sickness? 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 _____

Date of last blood test _____ Were they normal? _____

How often 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? _____

How much liquid do you drink per day? _____

How many mg of caffeine do you consume per day? _____

Other past medical history:

Operations? _____

_____

Ulcers or stomach problems? _____

_____

Asthma? _____

Any other medical conditions? _____

_____

_____

_____

Side effects or allergies to any medications? _____

_____

_____

What prescription and over-the-counter medications are you **currently** taking and what is the **dose**?

_____

_____

_____

_____

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

School

Time Management

Relationship/Interactions w/ children

Other (please list below)

Marriage

Financial Pressure

Relationship/Interactions w/ parents

none of the above

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 _____

_____

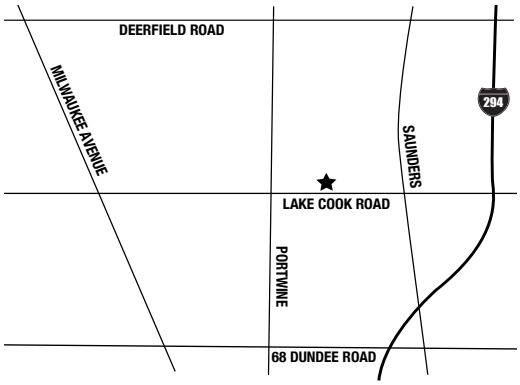
Suicidal thoughts (past or present) _____

_____

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 "**Global Sourcing Connection**" 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
☐	☐	☐	☐