YOUR Migraine Care MISSOULA

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406-926-1300 | YourMigraineCare.com

Patient Background Information

Name_____ Date _____

Age _____ Date of Birth _____

1. How often do you have headaches?

   _____ 1 - 7 per month

   _____ 7 - 15 per month

   _____ Over 15 per month

2. How long have you had headaches? _____

3. How do you rate your current pain? (Please circle one)

   1 2 3 4 5 6 7 8 9 10

4. How do you rate the severity of your pain at its worst? (Please circle one)

   1 2 3 4 5 6 7 8 9 10

5. What medications have you tried (alone or in combination) to treat your headaches?

_____

_____

_____

_____

_____

6. What other interventions or strategies have you tried?

_____

_____

_____

_____

_____

7. What other medical providers have you seen for your headaches?

_____

_____

_____

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_____

8. Have you ever been treated with xylocaine or novocaine for stitches or dental procedures?

___Yes ___No Any problems?_____

9. **Additional questions:**

Is your current headache new (never had before)?	Yes	No
Is your current headache a new headache type?	Yes	No
Is your current headache the "worst ever" headache?	Yes	No
Are your headaches increasing in frequency?	Yes	No
Do you experience sudden onset of very severe pain, reaching maximum intensity soon after onset?	Yes	No

Potential Migraine Headache Symptoms:

Before your headache, do you have any of the following symptoms? Please circle the appropriate number(s).

1) constipation
2) mood changes, from depression to euphoria
3) food cravings
4) neck stiffness
5) increased thirst and urination

Do you experience any of the following **aura symptoms**? Please circle the appropriate number(s).

1) visual phenomena, such as seeing various shapes, bright spots, or flashes of light
2) vision loss
3) pins and needles sensations in an arm or leg
4) weakness or numbness in the face or one side of the body
5) difficulty speaking
6) hearing noises or music

During a migraine, do you experience any of the following? Please circle the appropriate number(s).

1) pain on one side or both sides of your head
2) pain that feels throbbing or pulsing
3) sensitivity to light, sounds, and sometimes smells and touch
4) nausea and vomiting
5) blurred vision
6) lightheadedness, sometimes followed by fainting
7) uncontrollable jerking or other movements

After your migraine attack, do you experience any of the following? Please circle the appropriate number(s).

1) confusion
2) moodiness
3) dizziness
4) weakness
5) sensitivity to light and sound

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____