PELED SURGERY

HEADACHE HISTORY FORM

IF THIS IS YOUR FIRST VISIT, PLEASE TAKE THE TIME TO FILL THIS FORM OUT COMPLETELY.

Patient Name: _____ Age: _____ Date of Birth: _____ Weight: _____ Height:_____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-mail address _____ Emergency Contact _____
Emergency Contact Info_____
Emergency Contact relationship to you_____
Social Security#: _____ Occupation: _____
How did you hear about us? _____
Reason for today's visit: _____

Primary Care Physician: _____ Phone: _____ Fax_____
Address_____City/State_____Zip_____

Referring Physician: _____Phone: _____ Fax_____
Address_____City/State_____Zip_____

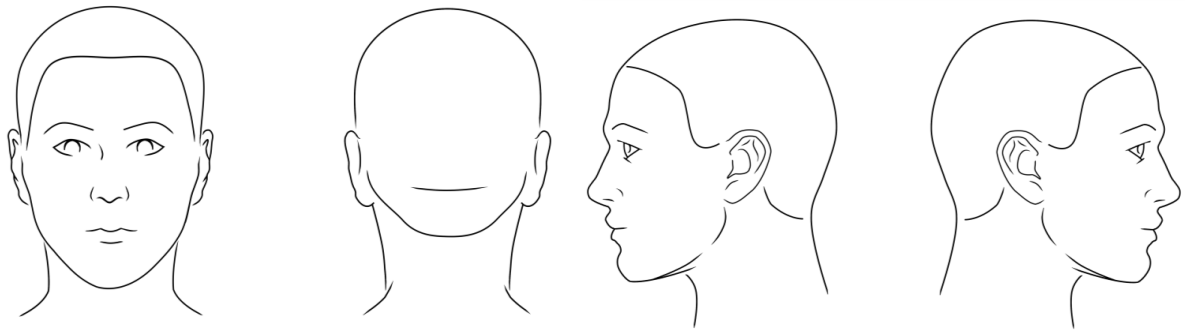
Primary Insurance:_____Phone #: _____
Address:_____Policy #:_____ Group #: _____
Policy Holder:_____ Social Security #: _____ DOB:_____

Secondary Insurance: _____Phone #: _____
Address:_____Policy #:_____ Group #: _____
Policy Holder:_____ Social Security #: _____ DOB:_____

PAYMENT OPTIONS:

- AMEX, MasterCard & Visa are accepted
- Personal checks are accepted **at least** 14 days prior to surgery
- Payment financing is available via Care Credit

- Who is your current treating physician? _____
- How many migraine headaches do you experience per month on average? _____
- How many regular headaches do you have per month on average? _____
- How painful are your migraine headaches? (Circle One Number)
  1 2 3 4 5 6 7 8 9 10
  Mild Severe
- Please draw where the pain starts and where it spreads. Use X for where it starts or is more severe, and arrows for where it spreads



- How long do your migraine headaches usually last? _____
- How old were you when your migraine headaches started? _____
- How would you describe your migraine headaches? (check all that apply)
  ☐ throbbing/pounding ☐ ache/pressure ☐ like a tight band ☐ other
- Do your migraine headaches awaken you at night? (check one)
  ☐ never ☐ occasionally ☐ often
- Do any of the following occur before or during your migraine headaches?
  ☐ nausea/vomiting ☐ runny nose ☐ bothered by light/noise
  ☐ blurry/double vision ☐ flashing/colored lights ☐ puffy eyelids
  ☐ other _____
- Do any of the following bring on your migraine headaches or make them worse?
  ☐ stress ☐ bright lights ☐ weather changes
  ☐ loud noise(s) ☐ heavy lifting ☐ fatigue
  ☐ other _____
- Do any of the following make your migraine headaches better?
  ☐ rest ☐ exercise ☐ quiet/darkness
  ☐ pressure on head ☐ massage ☐ vomiting
  ☐ other _____

- If you are female, do your migraine headaches change with any of the following?
  ☐ menstrual periods/pregnancy ☐ birth control pills/ other hormones
- Have you ever had a head or a neck injury requiring medical treatment?
  ☐ no ☐ yes If yes, describe _____
- Have you had your migraine headaches evaluated by a neurologist?
  ☐ no ☐ yes If yes, by whom and when _____
- What was the diagnosis? (check all that apply)
  ☐ migraine ☐ tension-type ☐ cluster ☐ other (specify) _____
- List all past tests you have had for your migraine headaches: _____
  _____
- List all past treatment(s) for your migraine headaches: _____
  _____
- To what extent do your migraine headaches affect your quality of life? (check one)
  ☐ extremely ☐ moderately ☐ very little ☐ none at all
- What activities in life have you given up because of your headaches? _____
  _____

Do **you currently** have any of the following conditions?

	YES	NO		YES	NO		YES	NO
EYES			**ENDOCRINE**			**GENITOURINARY**		
Cataract(s)	❑	❑	Insulin dependent diabetes	❑	❑	Pain w/ urination	❑	❑
Visual disturbance(s)	❑	❑	Diabetes controlled with pills	❑	❑	Kidney/bladder infection	❑	❑
Glaucoma	❑	❑	Diabetes controlled with diet	❑	❑	Kidney stone(s)	❑	❑
Retinal problems	❑	❑	Thyroid disease	❑	❑	Hysterectomy	❑	❑
EAR, NOSE, THROAT			Parathyroid disease	❑	❑	Blood in urine	❑	❑
Sore throat	❑	❑	Psychiatric disorders	❑	❑	Uterine fibroids	❑	❑
Chronic sinus drainage	❑	❑	**CARDIAC**			**MUSCOLOSKELETAL**		
Nasal breathing issues	❑	❑	Heart disease	❑	❑	Joint Pain/Swelling	❑	❑
RESPIRATORY			Heart attack	❑	❑	Herniated disk	❑	❑
Use oxygen at home	❑	❑	Angina	❑	❑	Arthritis	❑	❑
Emphysema	❑	❑	Heart failure	❑	❑	Back pain/injury	❑	❑
Asthma	❑	❑	Hypertension	❑	❑	**NEUROLOGIC**		
GASTROINTESTINAL			Pacemaker	❑	❑	Stroke	❑	❑
Chronic nausea	❑	❑	Cardiac bypass	❑	❑	TIA (AKA “minor stroke”)	❑	❑
Chronic vomiting	❑	❑	Cardiac catheterization	❑	❑	Migraines	❑	❑
Abdominal pain	❑	❑	Angioplasty	❑	❑	Neuropathy	❑	❑
Diarrhea	❑	❑	High cholesterol	❑	❑	**SKIN**		
Black/bloody stools	❑	❑	**HEME/LYMPH**			Moles	❑	❑
Hepatitis	❑	❑	Recent lymph node swelling	❑	❑	Poor scarring	❑	❑
Gall stones	❑	❑	Chronic lymph node swelling	❑	❑			
Hernia(s)	❑	❑						
Spleen problems	❑	❑						

PELED SURGERY

PAST MEDICAL HISTORY:

Have **you ever** had any of the following?

Anemia	❑ Yes	❑ No	Heart murmur	❑ Yes	❑ No	Mitral valve prolapse	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Rheumatic fever	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No	Skin cancer	❑ Yes	❑ No
Bleeding problem	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No	High blood pressure	❑ Yes	❑ No	Thyroid disease	❑ Yes	❑ No
Cancer (other)	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No	Seizures	❑ Yes	❑ No

If yes to any of the above, please describe the condition:_____

_____

_____

PAST SURGICAL HISTORY (including cosmetic surgery):

Please list any previous surgery with approximate dates:

Procedure	Date	Procedure	Date

FAMILY HISTORY:

Do you have **family members** with any of the following conditions:

Breast Cancer	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No
Other Cancer	❑ Yes	❑ No	Stroke	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No
MIGRAINES	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Depression	❑ Yes	❑ No

If yes to any of the above, please describe the condition and identify your relation to the family member:_____

_____

_____

MEDICATIONS:

Please list any prescription, non-prescription, and herbal medications you are taking along with doses. If you have a long list, please bring it to us.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

DRUG ALLERGIES:_____

SOCIAL HISTORY:

Marital Status: _____ Spouse's name _____

Are you currently employed? yes ___ no ___ If so, what do you do?_____

Do you smoke? yes ___ no ___ If so, how many packs per day? _____

If you smoked in the past, when did you quit? _____

On average, how many alcoholic drinks do you have per week? _____