At what age did you have your first headache: ________  What year did your current headaches begin: ________

When was your last headache: __________________________________________________________

Are you ever free of pain completely?  ☐ Yes  ☐ No

Do you have more than one type of headaches?  ☐ Yes  ☐ No

If yes, describe them separately: _______________________________________________________

How many headaches do you have each month: ________  How long do they last: ________

**HOW WOULD YOU DESCRIBE THE PAIN OF YOUR MOST BOTHERSOME HEADACHES:**
(circle all that apply)

- throbbing
- pulsating
- dull
- aching
- pressure-like
- sharp
- stabbing
- electric-like
- vise-like

**ARE YOUR HEADACHES BROUGHT ON BY:**
(circle all that apply)

- your periods/hormonal changes
- alcohol
- lack of sleep
- exercise
- bright light/glare
- too much sleep
- stress
- odors
- hunger
- relaxation after stress
- smoke
- food additives
- change in weather
- noise
- certain foods
Do your headaches occur on any particular day of the week or time of day? ______________________________

Do you have any warning signs before the start of a headache?  □ Yes  □ No
Describe: ____________________________________________

CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU HAVE WITH YOUR HEADACHES:

- neck pain
- nausea
- vomiting
- light sensitivity
- dizziness
- other ________________________________
- noise sensitivity
- numbness
- weakness
- fever
- confusion
- difficulty speaking
tearing
- nasal congestion
- eyelid drooping
- worsening of pain with movement
- neck pain
- nausea
- vomiting
- light sensitivity
- dizziness
- other ________________________________
- noise sensitivity
- numbness
- weakness
- fever
- confusion
- difficulty speaking
tearing
- nasal congestion
- eyelid drooping
- worsening of pain with movement

PLEASE INDICATE WITH X’S WHERE YOU EXPERIENCE PAIN:

Have you ever been treated for headaches?  □ Yes  □ No

What kind of headaches were you told you have: ________________________________________________

Have you ever had any tests done to diagnose your headaches?  □ Yes  □ No
Describe: ____________________________________________
WHICH OF THE FOLLOWING MEDICINES HAVE YOU TRIED FOR YOUR HEADACHES:
Circle all that apply | *Star those that helped, even for a short time

Anaprox     | Darvon / Darvocet     | Indocin / Indomethacin | Propranolol
Aspirin     | Dexamethasone / Decadron | Hydrocodone     | Relpax
Anacin      | Decongestants     | Lamicital     | Robaxin
Advil / Ibuprofen | DHE-45          | Lidocaine     | Stadol
Aleve / Naproxen | Demerol         | Lithium     | Talwin
Amerge      | Depakote     | Lyrica     | Topomax / Topiramate
Axert       | Desyrel / Tradozone | Maxalt     | Tylenol
Axotal      | Dilantin / Phenytoin | Midrin     | Ultram / Tramadol
Amitriptyline / Elavil | Effexor    | Mirgralex     | Ultracet
Atacand     | Esgic     | Migranal     | Valium
Benicar     | Ergostat     | Motrin / Ibuprofen     | Verapamil
Beta-blockers | Excedrin    | Neurontin / Gabapentin | Wigraine
Botox       | Fioricet / Butalbital | Panadol     | Xanax
Bufferin    | Fiorinal / Butalbital | Pamelor / Notriptylne | Zanaflex
Cafergot    | Flexeril     | Percocet / Oxycodone | Zomig
Calan       | Frova     | Percodan     | Zonegran
Cymbalta    | Imitrex / Sumatriptan | Percogesic     | Other:
Codeine     | Inderal / Propranolol | Phrenilin Forte

Please list major side effects of medication: __________________________________________________________

HAVE YOU TRIED ANY OF THE FOLLOWING ALTERNATIVE TREATMENTS (circle):
Biofeedback Chiropractic Supplements: (Feverfew, B2, Magnesium, MigreLief, CoQ10, Butterbur, Petadolex)
Acupuncture Physical Therapy
Other __________________________________________________________

3 of 8 Please complete all pages
**PATIENT HEALTH QUESTIONNAIRE-9 (PHQ9)**

Over the last two weeks, how often have you been bothered by any of the following problems? (use ✓ to indicate your answer)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
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<td>2. Feeling down, depressed, or hopeless</td>
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<td>3. Trouble falling or staying asleep, or sleeping too much</td>
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<td>4. Feeling tired or having little energy</td>
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<td>5. Poor appetite or overeating</td>
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<td>6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down</td>
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<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
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<tr>
<td>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</td>
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<tr>
<td>9. Thoughts that you would be better off dead or hurting yourself in some way</td>
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</tbody>
</table>

For office coding: ___ + ___ + ___ + ___

= 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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**Neurology Locations:**

- The Portland Clinic - South
  6640 SW Redwood Lane
  Portland, OR 97224
  (503) 620-7358

- The Portland Clinic - Downtown
  800 SW 13th Ave
  Portland, OR 97205
  (503) 221-0161

**THEPORTLANDCLINIC.COM**

4 of 8 Please complete all pages
CURRENT SYMPTOMS - IN THE LAST 6 MONTHS: (please mark all that apply)

1. Head, Eyes, Ears, Nose, Throat, Lymph Nodes:
   - Headaches
   - Double vision
   - Hoarseness of voice
   - Tinnitus (buzzing or humming)
   - Photophobia (light bothers eyes)
   - Swollen and/or painful lymph nodes
   - Head trauma
   - Deafness
   - Neck swelling
   - Pain and/or drainage from ears
   - Nasal and/or sinus congestion
   - Visual loss or change
   - Nose bleeds
   - Neck stiffness
   - Sore throat
   - Glaucoma
   - Teeth grinding / clenching
   - Hearing problems
   - Vision problems
   - Dental problems
   - Sinus problems

2. Respiratory System:
   - Shortness of breath
   - Sputum/secretion production
   - Wheezing
   - Cough
   - Hemoptysis (coughing up blood)
   - Breathing difficulty

3. Cardiovascular System:
   - Chest pain, discomfort, heaviness, tightness
   - Shortness of breath with exertion
   - PND (waking up short of breath)
   - Orthopnea (sleeping on two or more pillows)
   - Leg swelling
   - High blood pressure
   - Palpitations
   - Chest pain
   - Heartburn

4. Gastrointestinal System:
   - Anorexia (poor appetite)
   - Nausea and/or vomiting
   - Constipation or diarrhea
   - Weight loss or gain
   - Hematochezia (red blood in bowel movements)
   - Melena (black bowel movements)
   - Jaundice
   - Abdominal pain
   - Dysphagia (difficulty swallowing)
   - Stomach pain
   - Weight change:
     - loss ____ lbs , gain____lbs

5. Genitourinary System:
   - Hematuria
   - Oliguria (infrequent urination)
   - Incontinence
   - Heavy menstrual flow
   - Polyuria (urination of large volumes of urine)
   - Nocturia (urination at night)
   - Frequency (frequent urination)
   - Pyuria (cloudy urine)
   - Urgency (sensation to urinate)
   - Sexual dysfunction
   - Symptoms of menopause
   - Irregular periods
   - PMS
   - Bladder problems
   - Excessive urination or thirst

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11008 (3/15)
6. Nervous system:
   - Weakness/paralysis on one side of body
   - Urinary and/or fecal incontinence
     (wet or soiled underwear)
   - Memory loss, sleep disturbance,
     mood disorders (anxiety, depression)
   - Insomnia
   - Daytime sleepiness
   - Snoring
   - Sleep apnea
   - Seizures / shaking
   - Numbness
   - Loss of consciousness
   - Dizziness

7. Musculoskeletal System:
   - Joint pain / swelling / redness
   - Muscle aches and pains
   - Back pain
   - Neck pain
   - Leg / foot cramps
   - Leg restlessness

   — Weakness

8. Dermatological System:
   - Rash
   - Mole changes
   - Pigmentation (change in color)
   - Breast pain
   - Pruritus (itching)
   - Bleeding or bruising
   - Changes in nipples
   - Breast lumps / discharge

   — Allergic reaction
   — Change in skin / hair

PAST MEDICAL HISTORY:
Have you had or do you have any of the following conditions?

<table>
<thead>
<tr>
<th>Alcoholism</th>
<th>Arthritis</th>
<th>Asthma</th>
<th>Cancer</th>
<th>Chest Pain</th>
<th>Colitis</th>
<th>Depression / Anxiety</th>
<th>Diabetes</th>
<th>Drug Addiction</th>
<th>Emphysema</th>
<th>Frequent Kidney Infections</th>
<th>Frequent Bladder Infections</th>
<th>Gallbladder disease</th>
<th>Gout</th>
<th>High Blood Pressure</th>
<th>Headache</th>
<th>Hepatitis</th>
<th>Heart Attack</th>
<th>Jaundice</th>
<th>Kidney Disease</th>
<th>Other Heart Disease</th>
<th>Pain (Chronic)</th>
<th>Rheumatic Fever</th>
<th>Stomach Ulcers</th>
<th>Thyroid Disease</th>
<th>Trouble Sleeping</th>
<th>Suicidal Thoughts</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>No</td>
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Please complete all pages
### FAMILY HISTORY
Do you have a family member affected with:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Type/affected relative</th>
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</thead>
<tbody>
<tr>
<td>Brain Tumor</td>
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<td>Seizures or epilepsy</td>
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<td>Dementia</td>
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<td>Parkinson’s</td>
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<td>Multiple Sclerosis</td>
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<td>Thyroid Disease</td>
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Write other conditions: ______________________________________

### MEDICATION HISTORY

Please list all **MEDICATIONS** you take routinely, prescribed or over-the-counter, along with the dosages:

*(If you are a Portland Clinic patient and our list is up to date, leave blank.)*

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Dose:</th>
<th>Frequency:</th>
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Please list all allergies and sensitivities (e.g. medications, foods, latex, iodine, etc.)

__________________________________________________________________
### SURGERIES:
(List procedure and approximate year)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Year</th>
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