

Laura Bonds, M.D  
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Office: 936-267-0912  
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# Woodlands Neurology Clinic



## HEADACHE HISTORY

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**How old were you when you first started having headaches?** (Any type of headache, even if those headaches were different from your current headaches). \_\_\_\_\_

**Describe the location of your headache (if it begins in one area and spreads, describe it).**

\_\_\_\_ all over, \_\_\_\_ front, \_\_\_\_ side, \_\_\_\_ back, \_\_\_\_ one side (right or left), \_\_\_\_ both sides,  
\_\_\_\_ Variable, other: \_\_\_\_\_

**How would you describe your headaches?**

\_\_\_\_ blinding, \_\_\_\_ throbbing, \_\_\_\_ pressing, \_\_\_\_ squeezing, \_\_\_\_ stabbing/sharp,  
\_\_\_\_ dull/nagging/aching, \_\_\_\_ burning, other \_\_\_\_\_

**Please rate your headache on a scale of 0 to 10 under the following conditions:**

Lying down	0	1	2	3	4	5	6	7	8	9	10
Sitting quietly	0	1	2	3	4	5	6	7	8	9	10
Standing up	0	1	2	3	4	5	6	7	8	9	10
Exercising	0	1	2	3	4	5	6	7	8	9	10
In the morning	0	1	2	3	4	5	6	7	8	9	10
In the afternoon	0	1	2	3	4	5	6	7	8	9	10
In the evening	0	1	2	3	4	5	6	7	8	9	10
At night	0	1	2	3	4	5	6	7	8	9	10

**How long do the headaches last if untreated or unsuccessfully treated?**

\_\_\_\_ a few minutes or less, \_\_\_\_ a few hours, \_\_\_\_ 1 to 3 days  
\_\_\_\_ more than a week, other: \_\_\_\_\_

**When did the type of headache you are now suffering from begin?** \_\_\_\_\_

**How frequently do you have any headaches (days/months)?** \_\_\_\_\_

**How frequently do you have** mild \_\_\_\_\_, Moderate \_\_\_\_\_, severe \_\_\_\_\_, headaches?

**Headaches usually begin in the** morning / afternoon / evening / middle of the night?

**Have you noticed any factors that** trigger / aggravate the headaches?

If yes, please mark:

\_\_\_\_ emotional stress, \_\_\_\_ depression, \_\_\_\_ anxiety, \_\_\_\_ change in sleep pattern,  
\_\_\_\_ physical activity, \_\_\_\_ standing, \_\_\_\_ bending over, \_\_\_\_ straining, \_\_\_\_ coughing,  
\_\_\_\_ sexual activity, \_\_\_\_ missing a meal, \_\_\_\_ exposure to excessive sun or heat,  
\_\_\_\_ changes in weather, \_\_\_\_ changes in the barometric pressure, \_\_\_\_ alcohol,  
\_\_\_\_ Certain foods, \_\_\_\_ menstrual period, \_\_\_\_ birth control

**Along with your headache, please check any other symptoms you experience, even if you do not experience these symptoms on every occasion:**

\_\_\_\_ sensitivity to light, \_\_\_\_ vision change, \_\_\_\_ difficulty speaking, \_\_\_\_ sensitivity to noise,  
\_\_\_\_ nausea, \_\_\_\_ vomiting, \_\_\_\_ dizziness

**Are your headaches improved by anything (sleep, ice, heat, medication, darkness)?**

\_\_\_\_\_

**Do you have a visual aura before a headache? If yes, please describe your aura**

\_\_\_\_\_

**What percent of the time does the aura occur:**

\_\_\_\_ less than 25%, \_\_\_\_ 50%, \_\_\_\_ 75%, \_\_\_\_ 100%

**Since your current headache began, what is the longest amount of time that you have gone WITHOUT a headache?** \_\_\_\_\_

**How many days of work / school have you missed because of headaches?** \_\_\_\_\_

**How many times have you been to an acute care clinic or Emergency Room for your headaches?**

\_\_\_\_\_

**List any other care providers you have seen for headaches:**

\_\_\_\_\_

\_\_\_\_\_

**Have you ever been prescribed a medication for headaches which you took every day whether you had a headache or not? If so, please list the medication, the dose, the amount of time you took it, how well it worked for you and any problems you experienced from the medication:**

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**Please list any medications you have taken in the past for headaches, how the medicine worked as well as any problems you had with the medication (i.e. Aspirin helped mild headaches but caused an upset stomach).**

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**Have you ever had been evaluated previously by a Neurologist for your headaches? If so, please list the Neurologist's name, location, date of evaluation, diagnosis and treatment**

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**Have you ever had any diagnostic tests done for your headaches, such as CT scans or MRI's? If so, list the study, date and result if known.**

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**Do any of your blood relatives get headaches? If so, who and what types of headaches:**

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**Date of last eye exam? \_\_\_\_\_ Average Caffeine intake? \_\_\_\_\_**

## COMMON ACUTE HEADACHE TREATMENTS

(Generic and Brand Names)

Circle each therapy you have used

<p><b>Triptans</b></p> <table style="width: 100%; border: none;"> <tr><td>Naratriptan</td><td>Amerge</td></tr> <tr><td>Almotriptan</td><td>Axert</td></tr> <tr><td>Frovatriptan</td><td>Frova</td></tr> <tr><td>Sumatriptan</td><td>Imitrex</td></tr> <tr><td></td><td>Onzetra</td></tr> <tr><td></td><td>Zembrace</td></tr> <tr><td></td><td>Sumavel</td></tr> <tr><td></td><td>Tosymra</td></tr> <tr><td></td><td>Treximet</td></tr> <tr><td></td><td>Zembrace</td></tr> <tr><td>Rizatriptan</td><td>Maxalt</td></tr> <tr><td>Eletriptan</td><td>Relpax</td></tr> <tr><td>Zolmitriptan</td><td>Zomig</td></tr> </table>	Naratriptan	Amerge	Almotriptan	Axert	Frovatriptan	Frova	Sumatriptan	Imitrex		Onzetra		Zembrace		Sumavel		Tosymra		Treximet		Zembrace	Rizatriptan	Maxalt	Eletriptan	Relpax	Zolmitriptan	Zomig	<p><b>NSAIDS</b></p> <table style="width: 100%; border: none;"> <tr><td>Ibuprofen</td><td>Advil</td></tr> <tr><td></td><td>Motrin</td></tr> <tr><td>Naproxen</td><td>Aleve</td></tr> <tr><td>Aspirin</td><td>BC Powder</td></tr> <tr><td></td><td>Goody's</td></tr> <tr><td></td><td>Powder</td></tr> <tr><td>indomethacin</td><td>Indocin</td></tr> <tr><td>ketorolac</td><td>Toradol</td></tr> <tr><td>diclofenac</td><td>Cambia</td></tr> <tr><td></td><td>Zipsor</td></tr> <tr><td></td><td>Voltaren</td></tr> <tr><td>Meloxicam</td><td>Mobic</td></tr> </table>	Ibuprofen	Advil		Motrin	Naproxen	Aleve	Aspirin	BC Powder		Goody's		Powder	indomethacin	Indocin	ketorolac	Toradol	diclofenac	Cambia		Zipsor		Voltaren	Meloxicam	Mobic	<p><b>COX-2 Inhibitors</b></p> <table style="width: 100%; border: none;"> <tr><td>Celecoxib</td><td>Celebrex</td></tr> <tr><td>Vadecoxib</td><td>Bextra</td></tr> <tr><td>Fofecoxib</td><td>Vioxx</td></tr> </table> <p><b>Barbiturates</b></p> <table style="width: 100%; border: none;"> <tr><td>Butalbital</td><td>Esgic</td></tr> <tr><td></td><td>Fioricet</td></tr> <tr><td></td><td>Florinal</td></tr> <tr><td></td><td>Phrenllin</td></tr> </table>	Celecoxib	Celebrex	Vadecoxib	Bextra	Fofecoxib	Vioxx	Butalbital	Esgic		Fioricet		Florinal		Phrenllin
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**COMMON HEADACHE PREVENTIVE THERAPIES  
(Generic and Brand Names)**

Circle each therapy you have used

<p><b>Beta-blockers</b></p> <p>Timolol            Betimol Nadolol            Corgard Metoprolol        Toprol                           Lopressor Propranolol        Inderal Atenolol            Tenormin Nebivolol          Bystolic</p>	<p><b>TCA's</b></p> <p>Amitriptyline     Elavil Nortriptyline     Pamelor Protriptyline     Vivactil Desipramine       Norpramin Imipramine        Tofranil Doxepin            Silenor</p>	<p><b>Antiepileptics</b></p> <p>Divalproex/valproic acid Depakote Leveturacetarn            Keppra Lamotrigine                Lamictal Zonisamide                Zonegran Topiramate                 Topamax                                       Trokendi XR Gabapentin                 Neurontin                                       Gralise                                       Horizant Pregabalin                 Lyrica Acetazolamide             Diamox Lacosamide                Vimpat Carbamazepine            Tegretol Oxcarbazepine            Trileptal Primidone                  Mysoline</p>
<p><b>Calcium channel blockers</b></p> <p>Verapamil        Verelan Amlodipine       Norvasc Diltiazem        Cardizem Nifedipine        Procardia nimodipine</p>	<p><b>SSRIs</b></p> <p>Fluoxetine        Prozac Fluvoxamine      Luvoz Escitalopram     Lexapro Paroxetine        Paxil Sertraline         Zoloft Citalopram        Celexa</p>	<p><b>SNRIs</b></p> <p>Venlafaxine       Effexor Desvenlafaxine    Pristiq Milnacipran        Savella Duloxetine         Cymbalta Levomilnacipran   Fetzima Sibutramine        Meridia Atomoxetine        Strattera</p>
<p><b>CGRPs</b></p> <p>Aimovig Ajovy Emgality</p>	<p><b>Other:</b></p>	

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Migraine Prescription Agreement

I agree as a condition of being treated by Dr. Bonds, that I will not fill or refill any prescription prescribed by another physician for the treatment of migraines.

Any violation of this agreement will result in termination of the physician patient relationship.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_