

HEADACHE CENTER FOLLOW-UP FORM



A Department of Baylor University Medical Center at Dallas

DATE: _____

PATIENT NAME: _____

DOB: _____

Headache Control Poor Fair Good Excellent
Benefit of Headache Medication Poor Fair Good Excellent

Pain Medication for Headache: (Mark all that apply)

- Taking prescription pain medication less than monthly
- Taking prescription pain medication monthly
- Taking prescription pain medication between 4-6 days per month
- Taking prescription pain medication weekly
- Taking prescription pain medication more than 2 days per week
- Taking prescription pain medication almost daily or daily
- Not taking over-the-counter pain medication
- Taking over-the-counter pain medication between 2-4 days per week
- Taking over-the-counter pain medication 5 days a week or more

Side effects of headache medication:

- Yes
- No

How often are you having Headache:

- Less than monthly
- Monthly
- Between 4-6 days per month
- Weekly
- 2 days or more per week
- Almost daily
- Daily

For Female Patients:

- Considering pregnancy in near future
- Pregnant or possibly pregnant
- On birth control pill
- Smoke cigarettes (or cigars)
- Increased headache with period
- Perimenopausal or premenopausal
- Menopause
- Taking hormone replacement

New Symptoms Since Starting Headache Medication: (Check if Applicable)

<input type="checkbox"/> None <input type="checkbox"/> Rash <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Confusion <input type="checkbox"/> Drowsiness/sedation <input type="checkbox"/> Memory loss <input type="checkbox"/> Fatigue/lethargy <input type="checkbox"/> Agitation/nervous <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Trouble falling asleep <input type="checkbox"/> Tremors <input type="checkbox"/> Dry mouth <input type="checkbox"/> Decreased sexual interest <input type="checkbox"/> Impotence <input type="checkbox"/> Eye pain <input type="checkbox"/> Blurred vision <input type="checkbox"/> Dizziness/lightheadedness <input type="checkbox"/> Increased heart rate/palpitation <input type="checkbox"/> Difficulty with urination <input type="checkbox"/> Incoordination <input type="checkbox"/> Muscle spasms/stiffness
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Social History: Changes in Life Issues Since Last Appointment:

<input type="checkbox"/> None <input type="checkbox"/> Change at work <input type="checkbox"/> New Job <input type="checkbox"/> Financial Issues	<input type="checkbox"/> New Family Problems <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Marital Conflict	<input type="checkbox"/> Death of loved one <input type="checkbox"/> Started School <input type="checkbox"/> School problems <input type="checkbox"/> Insomnia
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Medical History: Please list any previous and/or current illnesses and treatments (Ex: diabetes, cancer, etc.)

**BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS**



52671 (08/10)

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