

Your Name: \_\_\_\_\_ Your Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_



PHOENIX  
HEADACHE  
INSTITUTE

*Rise to Freedom*

## NOTICE REGARDING IMPORTANCE OF NEW PATIENT PAPERWORK

- This “New Patient Medical History” form must be completed in detail and in its entirety PRIOR to your scheduled appointment. You will NOT have time to complete this form in our office before you are scheduled to see the health care provider at PHI (PHI HCP).
- If this form is not fully completed and available at the time of your appointment, you will be asked to reschedule your appointment with the PHI HCP.
- Depending on the complexity of your medical history, this form may take you considerable time and effort to complete; do not wait until the last minute to complete.
- To complete this form, you may need to “track-down” several key components of your medical history such as previous medical records, imaging studies, laboratory results, etc.
- Please bring in the actual films (or CD’s) of any previous neuroimaging (anything involving your head or neck) studies; your PHI HCP wants to view them for themselves. You must also have the reports for these studies.
- You may want to have a family member or friend help you complete this paperwork and be present with you for your appointment with the PHI HCP.
- Headache Medicine is a detail-oriented subspecialty. The more details you can provide, the more likely we will be able to help you. You may be one detail away from the correct diagnosis and/or effective treatment.

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# PHOENIX HEADACHE INSTITUTE

*Rise to Freedom*

Who is your primary care provider? \_\_\_\_\_

Who is your referring medical provider? \_\_\_\_\_

Do you currently have a neurologist and / or pain specialist? \_\_\_yes \_\_\_no

If so, who are they? \_\_\_\_\_

\_\_\_\_\_

How did you do hear about us? \_\_\_\_\_

What brings you to our clinic? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you think is causing your pain? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are the three biggest goals you have regarding your pain? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are the three most important qualities you are looking for in your health care provider at Phoenix Headache Institute (HCP PHI)?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Your Name: \_\_\_\_\_ Your Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

➤ Onset and Timing of Your Pain:

- When did you experience your *first* headache (of any type)? \_\_\_\_\_
- When did your headaches first became *problematic* for you? \_\_\_\_\_
- Do you experience headache of any type *at least half the days out of the month*? \_\_\_yes \_\_\_no  
If so, for how many months has this been the case? \_\_\_months
- Do you experience headache every day? \_\_\_yes \_\_\_no  
If so, for how long has this been the case? \_\_\_\_\_
- If your headaches are every day, are they also every minute of every day? \_\_\_yes \_\_\_no  
If so, for how long has this been the case? \_\_\_\_\_
- Is there anything that you can think of that may have caused your headaches to take a dramatic turn for the worse? \_\_\_head trauma \_\_\_motor vehicle accident \_\_\_whiplash injury \_\_\_surgical procedure  
\_\_\_meningitis \_\_\_infection \_\_\_cancer \_\_\_new medication \_\_\_increased use of a medication  
\_\_\_pregnancy \_\_\_after child birth \_\_\_stressful / change of life event \_\_\_other

Notes: \_\_\_\_\_

- Have you ever experienced a headache that went from *no (or little)* pain to *excruciating* pain within a matter of *seconds*? \_\_\_yes \_\_\_no  
If so, explain: \_\_\_\_\_
- When you experience a headache (or headache flare up), how long does it last when you treat with medications? \_\_\_\_\_ How long does it last *without* medications or treatment? \_\_\_\_\_
- Once a headache starts, how long does it usually take to reach *maximum* intensity? \_\_\_\_\_
- What is the *longest* length of time you have experienced a headache? \_\_\_\_\_
- Do you experience multiple *distinct* attacks of headache per day? \_\_\_yes \_\_\_no  
If so, how many *distinct attacks* do you *typically* experience per day? \_\_\_ What is the *most number* of attacks you have experienced *in a day*? How *long* do these attacks *typically* last? \_\_\_\_\_  
What is the *longest length* of any one of these attacks? \_\_\_\_\_
- What percentage of the time do your headaches start when you are asleep? \_\_\_\_\_%  
Do you commonly wake up with headaches? \_\_\_yes \_\_\_no  
If so, do you think your headaches actually *wake you up*? \_\_\_yes \_\_\_no  
If so, how long after you fall asleep do they typically wake you up? \_\_\_\_\_

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➤ Headache Severity:

- On a scale from 0 to 10 (0= no pain and 10= worst pain of any type experienced), what is your average headache pain severity? \_\_\_\_\_
- On a scale from 0 to 10 (0= no pain and 10= worst pain of any type experienced), what is the *highest* headache pain severity you have experienced? \_\_\_\_\_
- How often are your headaches of moderate to severe intensity (levels 4, 5, 6, 7, 8, 9 or 10)?  
\_\_\_never \_\_\_seldom \_\_\_occasionally \_\_\_usually \_\_\_always
- In the *last 30 days*, you have experienced: \_\_\_severe (levels 8, 9 and 10) headache days, \_\_\_moderate (levels 4, 5, 6 and 7) headache days and \_\_\_mild (levels 1, 2 and 3) headache days.

➤ Other Symptoms Associated with Headache:

- You can \_\_\_never \_\_\_seldom \_\_\_occasionally \_\_\_usually \_\_\_always sense that a headache is coming *before* it actually occurs.  
If so, you can tell this by \_\_\_\_\_
- You \_\_\_never \_\_\_seldom \_\_\_occasionally \_\_\_usually \_\_\_always experiences other symptoms such as \_\_\_visual changes \_\_\_dizziness / vertigo \_\_\_numbness \_\_\_weakness \_\_\_trouble speaking \_\_\_passing out \_\_\_other (\_\_\_\_\_). These symptoms typically last \_\_\_\_\_. These symptoms typically occur \_\_\_before \_\_\_during \_\_\_after your headaches. Notes: \_\_\_\_\_
- Your headaches are \_\_\_never \_\_\_seldom \_\_\_occasionally \_\_\_usually \_\_\_always associated with *nausea*, even if mild.
- Your headaches are \_\_\_never \_\_\_seldom \_\_\_occasionally \_\_\_usually \_\_\_always associated with *vomiting*.
- Your headaches are \_\_\_never \_\_\_seldom \_\_\_occasionally \_\_\_usually \_\_\_always associated with *sensitivity to light*, even if mild.
- Your headaches are \_\_\_never \_\_\_seldom \_\_\_occasionally \_\_\_usually \_\_\_always associated with *sensitivity to sounds*, even if mild.
- Your headaches are \_\_\_never \_\_\_seldom \_\_\_occasionally \_\_\_usually \_\_\_always associated with *sensitivity to odors*, even if mild.

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- Your headaches are \_\_\_never \_\_\_seldom \_\_\_occasionally \_\_\_usually \_\_\_always associated with *skin* sensitivity to the touch. If so, this skin sensitivity is in \_\_\_your head \_\_\_the rest of your body.
  - During your headaches (or flare ups of your headache), you \_\_\_never \_\_\_seldom \_\_\_occasionally \_\_\_usually \_\_\_always experience symptoms of \_\_\_tearing \_\_\_abnormal pupil size / shape \_\_\_drooping eyelid(s) \_\_\_swelling around the eye(s) \_\_\_reddening of the eye(s) \_\_\_a runny nose \_\_\_a stuffy nose \_\_\_reddening of the face \_\_\_reddening of the ear(s) \_\_\_the skin of the face becoming hot. These symptoms are usually \_\_\_on the side of the pain \_\_\_on the opposite side of the pain \_\_\_on both sides.
  - At times you may also experience \_\_\_vertigo / dizziness \_\_\_neck pain \_\_\_shoulder pain \_\_\_anxiety \_\_\_problems thinking \_\_\_numbness \_\_\_problems talking or understanding someone \_\_\_slurred speech \_\_\_passing out \_\_\_confusion \_\_\_seizures \_\_\_weakness \_\_\_abdominal pain \_\_\_diarrhea \_\_\_other (\_\_\_\_\_) with your headaches. Notes: \_\_\_\_\_
- 

#### ➤ Quality of Headache Pain:

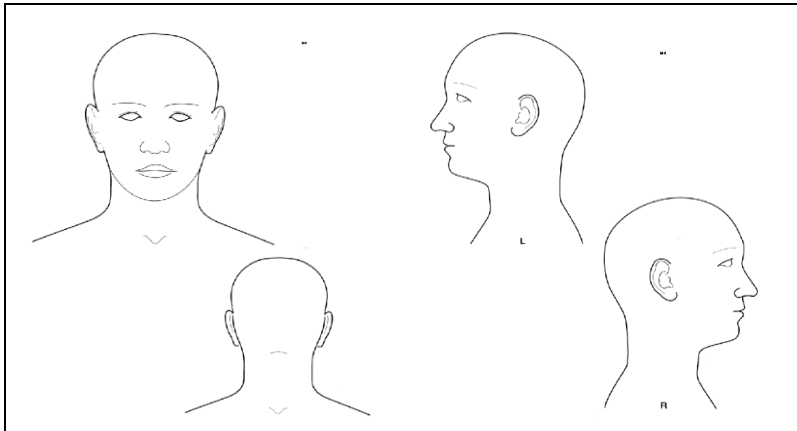
- Your headaches are \_\_\_never \_\_\_seldom \_\_\_occasionally \_\_\_usually \_\_\_always associated with a *pounding or throbbing* quality.
- Other descriptors of the quality of your headache pain would include: \_\_\_sharp \_\_\_dull \_\_\_achy \_\_\_shooting \_\_\_stabbing \_\_\_cramping \_\_\_gnawing \_\_\_boring \_\_\_maddening \_\_\_heavy \_\_\_tender \_\_\_burning \_\_\_splitting \_\_\_tiring / exhausting \_\_\_sickening \_\_\_punishing \_\_\_cruel \_\_\_suicidal \_\_\_fearful \_\_\_pressure \_\_\_squeezing

#### ➤ Location of Head Pain and Other Pain Conditions:

- Your headaches are \_\_\_never \_\_\_seldom \_\_\_occasionally \_\_\_usually \_\_\_always one-sided. [right, left, right or left].  
If your headaches are always one-sided, what side is affected? \_\_\_right \_\_\_left  
If your headaches are always one-sided, do you have times when you are *totally (100%)* pain-free on the affected side? \_\_\_yes \_\_\_no.

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- Put an "X" where your headache pain is *most commonly* the *worst*. Also shade (the *darker* the shade, the *more* the pain) in other areas where you experience head and neck pain.

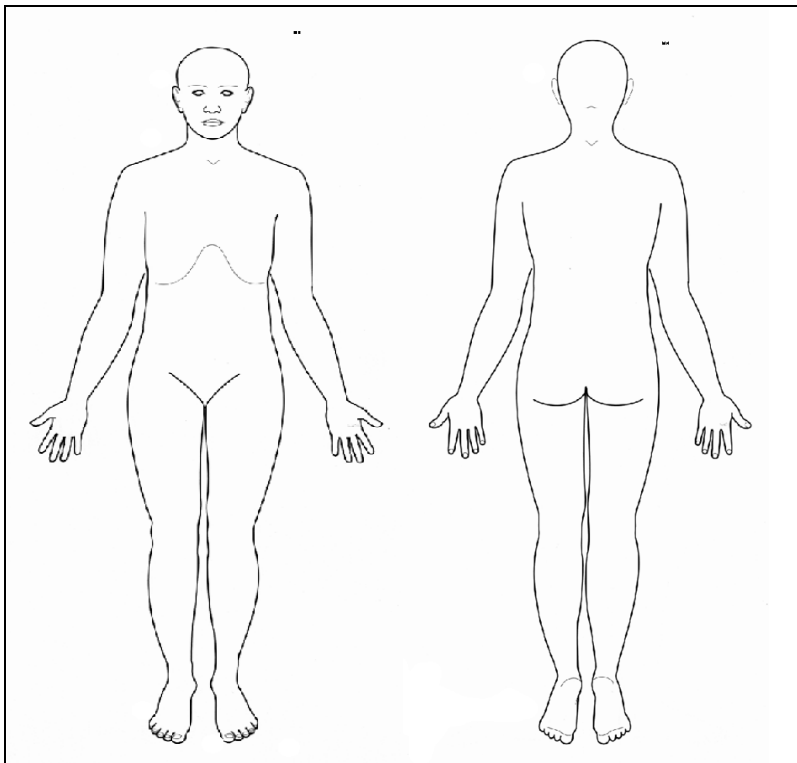


-On Average, how many days per week (0-7) do you use *any type* of pain medicine to treat your *head* pain? \_\_\_days

-For how long has this been the case? \_\_\_\_\_

-What medicine do you typically treat with? \_\_\_\_\_

- Put an "X" where you *most commonly* experience the *worst non-headache* related pain. Also shade (the *darker* the shade, the *more* the pain) other areas of *non-headache* related pain.



-On Average, how many days per week (0-7) do you use *any type* of pain medicine to treat your *non-headache* pain? \_\_\_days

-For how long has this been the case? \_\_\_\_\_

-What medicine do you typically treat your *non-headache* pain with? \_\_\_\_\_

-Who is treating you for your *non-headache* pain? \_\_\_\_\_

-Are these "other" pains worse than your headaches? \_\_\_yes  
\_\_\_no \_\_\_same



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- Complete the following chart to summarize your *previously attempted acute* headache treatments. These include “over-the-counter”, prescription or “natural” medicines used to *stop an existing headache*.

Name of Medication	Previously Used ? Yes or No	Max Dose Used	Route of Use	Length of Use	Overall Effectiveness (0= not effective at all & 10= ideal effectiveness)	Overall Side Effects (0= no side effects & 10= intolerable side effects) What were they?
Aleve®/Naproxyn Sodium						
Bayer® Aspirin or Alka Seltzer®/ASA						
Excedrin®/(ASA/APAP/CAFF)						
Motrin®/Ibuprofen						
Tylenol®/acetaminophen						
Esgic [Plus]® or Phrenilin/(APAP/CAFF/[BUT])						
Fioricet®/(APAP/CAFF/BUT)						
Fiorinal®/ (ASA/CAFF/BUT)						
Midrin®/ (ISO/DICH/APAP)						
Ergomar®/Ergotamine Tartrate						
Wigraine® or Cafergot®/(Ergot/CAFF)						
DHE-45®/Dihydroergotamine						
Migranal® Nasal Spray/DHE NS						
Amerge®/Naratriptan						
Axert®/Almotriptan						
Frova®/Frovatriptan						
Imitrex®/Sumatriptan						
Maxalt®/Rizatriptan						
Relpax®/Eletriptan						
Sumavel Dose Pro®/ SC Sumatriptan						
Treximet®/(Suma/Nap Sod)						
Zomig®/Zolmitriptan						
Ansaid®/Flurbiprofen						
Bextra®/Valdecoxib						
Cambia®/Diclofenac Potassium Powder						
Celebrex®/Celecoxib						
Feldene®/Piroxicam						
Indocin®/indomethacin						
Lymbrel®/Flavocoxid						
Mobic®/Meloxicam						
Orudis®/Ketoprofen						
Toradol®/Ketoralac						
Vioxx®/Rofecoxib						
Decadron®/Dexamethasone						
Medrol Dose Pack®/Methylprednisolone						



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Acute Medication Chart Continued

Name of Medication	Previously Used ? Yes or No	Max Dose Used	Route of Use	Length of Use	Overall Effectiveness (0= not effective at all & 10= ideal effectiveness)	Overall Side Effects (0= no side effects & 10= intolerable side effects) What were they?
Compazine®/Prochlorperazine						
Haldol®/Haloperidol						
Phenergan®/Promethazine						
Reglan®/Metoclopramide						
Seroquel®/Quetiapine						
Thorazine®/Chlorpromazine						
Zofran®/Odansetron						
Flexeril®/Cyclobenzaprine						
Lioresal®/Baclofen						
Skelaxin®/Metaxalone						
Soma®/Carisoprodol						
Zanaflex®/Tizanidine						
Ativan®/Lorazepam						
Klonopin®/Clonazepam						
Restoril®/Temazepam						
Valium®/Diazepam						
Xanax®/Alprazolam						
Lidocaine Nasal Spray						
Lidoderm® Patches						
Headache Buster® Nasal Spray						
Ambien®/Zolpidem						
Vistaril®/Hydroxyzine						
Benadryl®/Diphenhydramine						
Ultram®/Tramadol						
Actiq®/Fentanyl Lollipop						
Avina® or Kadian®/Morphine Sulfate						
Darvon® or Darvocet®/([APAP]/Propoxyphene)						
Demerol®/Meperidine						
Dilaudid®/Hydromorphone						
Duragesic®/Fentanyl Patch						
Lorcet® or Lortab®/(APAP/Hydrocodone)						
Methadose®/Methadone						
MS Contin® or MSIR®/Morphine Sulfate						
Percocet®/(APAP/Oxycodone)						
Stadol® Nasal Spray/Butorphanol						
Subutex® or Suboxone®/Buprenorphine						
Tylenol #3 or #4/(APAP/COD)						
Vicodin [ES]® or Norco® /(APAP/Hydrocodone)						
Oxygen						
Other						

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➤ Prophylactic Treatments for Headaches: How Do You Prevent Your Headaches?

- What is your current medical regimen for preventing your headaches? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- How would you rate the *overall effectiveness* of your *current preventative treatment regimen* (regimen you described above) on a scale from 0 to 10, where 0= not effective at all and 10= ideal effectiveness?  
 \_\_\_\_\_ How could it be made better? \_\_\_\_\_
- How would you rate the *side effects* of your *current preventative treatment regimen* (regimen you described above) on a scale from 0 to 10, where 0= no side effects and 10= intolerable side effects?  
 \_\_\_\_\_ What side effects are you experiencing? \_\_\_\_\_
- Complete the following chart to summarize your previous *procedural interventions* attempted for the management of your *headaches*.

Procedure	Previously Used ?	Date(s) Performed	Overall Effectiveness (0= not effective at all & 10= ideal effectiveness)	Overall Side Effects (0= no side effects & 10= intolerable side effects)
Botox® / Chemodenervation				
Trigger Point Injections				
Occipital Nerve Blocks				
Occipital Nerve Stimulation				
Supraorbital Nerve Blocks				
Cervical Epidurals				
Cervical Facet Blocks				
Cervical Spine Surgery				
Blood Patch				
CPAP for Sleep				
Palate Surgery				
Hole in Heart (PFO) Closed				
TMJ Surgery				
Other:				
Other:				

Your Name: \_\_\_\_\_ Your Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

- Complete the following chart to summarize your previously attempted “complementary and alternative” approaches to headache control.

Treatment Modality	Previously Used ? Yes or No	Date(s) Performed	Overall Effectiveness (0= not effective at all & 10= ideal effectiveness)	Overall Side Effects (0= no side effects & 10= intolerable side effects)
Acupuncture				
Homeopathic Medicine				
TENS Unit				
Traction / Inversion				
Chiropractic Manipulation				
Massage Therapy				
Osteopathic Manipulative Rx				
Exercise Therapy				
Formal Stretching Program				
Physical Therapy				
Biofeedback				
Cognitive-Behavioral Therapy				
Hypnosis				
Relaxation Therapy / Meditation				
Allergy Desensitization				
“Migraine-Free” Diet				
Dental Splint				
Transcranial Magnetic Stimulation				
Other:				
Other:				
Other:				

- Do you have any additional comments regarding your previous procedures and “complementary and alternative approaches” to headache control? \_\_\_yes \_\_\_no

If so, what are they \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- Are you potentially interested in additional “complementary and alternative approaches” to your headaches? \_\_\_yes \_\_\_no

If so, which ones in particular? \_\_\_\_\_  
 \_\_\_\_\_

- Are you interested in exploring any (additional) natural medicines (nutraceuticals) for the treatment of your headaches? \_\_\_yes \_\_\_no Comments: \_\_\_\_\_

Your Name: \_\_\_\_\_ Your Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

- Complete the following chart to summarize your *previously attempted preventative headache treatments*. These include “over-the-counter”, prescription and “natural” medicines used to *prevent future headaches*.

Name of Medication	Previously Used ? Yes or No	Max Dose Used	Length of Use	Overall Effectiveness (0= not effective at all & 10= ideal effectiveness)	Overall Side Effects (0= no side effects & 10= intolerable side effects) What were they?
Ergomar®/Ergotamine Tartrate					
Methergine®/Methylergonovine					
Sansert®/Methysergide					
Nardil®/Phenelzine					
Parnate®/Tranlycypromine					
Anafranil®/Clomipramine					
Desaryl®/Trazadone					
Doxepin®/Sinequan					
Elavil®/Amitriptyline					
Norpramine®/Desipramine					
Pamelor®/Nortriptyline					
Vivactil®/Protriptyline					
Celexa®/Citalopram					
Lexapro®/Escitalopram					
Paxil®/Paroxetine					
Prozac®/Fluoxetine					
Serzone®/Nefazodone					
Zoloft®/Sertraline					
Cymbalta®/Duloxetine					
Effexor®/Venlafaxine					
Savella®/Milnacipran					
Wellbutrin®/Bupropion					
Geodon®/Ziprasidone					
Remeron®/mirtazapine					
Seroquel®/Quetiapine					
Zyprexa®/Olanzapine					
Depakote®/Valproic Acid					
Gabril®/Tiagabine					
Keppra®/Levetiracetam					
Lamictal®/Lamotrigine					
Lyrica®/Pregabalin					
Neurontin®/Gabapentin					
Tegretol®/Carbamazepine					
Topamax®/Topiramate					
Trileptal®/Oxcarbazepine					
Zonegran®/Zonisamide					
Blocadren®/Timolol					
Corgard®/Nadolol					
Inderal®/Propranolol					
Lopressor® or Toprol®/Metoprolol					

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Preventative Medication Chart Continued

Name of Medication	Previously Used ? Yes or No	Max Dose Used	Length of Use	Overall Effectiveness (0= not effective at all & 10= ideal effectiveness)	Overall Side Effects (0= no side effects & 10= intolerable side effects) What were they?
Tenormin®/Atenolol					
Atacand®/Candesartan					
Calan®/Verapamil					
Cardene®/Nicardipine					
Cardizem®/diltiazem					
Minipres®/Prazosin					
Nimotop®/Nimodipine					
Procardia®/Nifedipine					
Rogaine®/Minoxidil					
Periactin®/Cyproheptadine					
Singulair®/Montelukast					
Celebrex®/celecoxib					
Indocin®/indomethacin					
Alpha-Lipoic Acid					
Boswellia					
Capsaicin					
CoEnzyme Q10					
Feverfew					
Magnesium					
Melatonin					
Petadolex®/Butterbur					
Riboflavin/Vitamin B2					
Taurine					
Lithonate®/Lithium					
Diamox®/Acetazolamide					
Lasix®/Furosemide					
Ativan®/Lorazepam					
Estrogen					
Progesterone					
Avina® or Kadian®/Morphine Sulfate					
Duragesic®/Fentanyl Patch					
Methadose®/Methadone					
MS Contin® or MSIR®/Morphine Sulfate					
TransdermScop®/Scopolamine					
Other:					
Other:					
Other:					
Other:					
Other:					

Comments:

\_\_\_\_\_

\_\_\_\_\_

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- Put an "X" in the box by any medical condition that you have and note any important details.

System / Medical Condition	Notes
<b>BRAIN &amp; SPINAL CORD</b>	
Carotid dissection (torn artery in / to head)	
Chiari malformation ("low lying brain")	
CNS tumor (brain or spinal cord tumor)	
CSF leak (spinal fluid leak)	
Cerebral palsy	
Cognitive impairment (memory problems)	
Dementia (Alzheimer's disease)	
Epilepsy (seizures)	
Head trauma	
Herpes zoster / post herpetic neuralgia (shingles)	
Intracranial aneurysms ("weak arteries in head")	
Meningitis ("brain infection")	
Migraine headache or cluster headache	
Multiple sclerosis	
Myopathy / muscular dystrophy ("muscle disease")	
Neuropathy ("nerve disease" in legs / arms)	
Optic neuritis (swelling of nerve to eye)	
Parkinson's disease	
Pseudotumor cerebri (too much pressure in head)	
Reflex sympathetic dystrophy (RSD)	
Stroke	
Syncope (passing out)	
Transient ischemic attack ("mini-stroke")	
Other:	
<b>MENTAL HEALTH</b>	
Alcohol / drug problems	
Anxiety	
Bipolar disorder	
Depression	
Personality disorder	
Physical, emotional or sexual abuse	
Post-traumatic stress disorder	
Prior suicide attempt	
Schizophrenia	
Other:	
<b>EYES &amp; VISION</b>	
Cataracts ("cloudy" lens in eyes)	
Glaucoma (too much pressure in eyes)	
Macular degeneration	
Retinopathy (problems with nerve in back of eyes)	
Other:	
<b>EARS, NOSE, THROAT &amp; TEETH</b>	
Acute sinusitis (sinus infection)	
Allergic rhinitis / seasonal rhinitis ("allergies")	
Chronic sinusitis (chronic sinus infection)	
Dental cavities / dental problems	
Sinus Headaches	
TMJ problems (jaw problems)	
Other:	
<b>HEART &amp; BLOOD VESSELS</b>	
Atrial-septal defect ("hole in heart")	
Cardiac arrhythmia (irregular heart beat)	
Coronary artery disease ("clogged arteries in heart")	
High cholesterol / triglycerides	
Hypertension (high blood pressure)	
Hypotension (low blood pressure)	
Myocardial infarction (heart attack)	
Patent foramen ovale ("hole in heart")	
Peripheral vascular disease ("clogged arteries in legs")	
Syncope (passing out)	
Valvular disease (abnormal heart valves)	
Other:	
<b>LUNGS</b>	
Asthma	
COPD (emphysema)	
Lung cancer	
Obstructive sleep apnea	
Other:	

System / Medical Condition	Notes
Pulmonary coccidioidomycosis ("Valley fever")	
Pulmonary embolism (blood clot in lung)	
Other:	
<b>STOMACH &amp; INTESTINES</b>	
Cirrhosis	
Colon cancer	
Peptic ulcer disease (stomach ulcers)	
Gastrointestinal bleeding	
Cholelithiasis ("slow" gallbladder or gall stones)	
GERD (acid reflux)	
Crohn's disease	
Ulcerative colitis	
Irritable bowel syndrome (IBS)	
Liver disease	
Rectal cancer	
Other:	
<b>KIDNEYS &amp; BLADDER</b>	
Kidney or bladder cancer	
Renal calculi (kidney stones)	
Renal insufficiency (kidney impairment / problems)	
Other:	
<b>MUSCLES &amp; BONES</b>	
Connective tissue disorder ("double jointed")	
Chronic cervical pain (neck problems)	
Chronic lumbar pain (low back problems)	
Fibromyalgia	
Osteoarthritis (general arthritis)	
Rheumatoid arthritis	
Gout	
Osteoporosis ("weak / brittle bones")	
Other:	
<b>BLOOD &amp; IMMUNE SYSTEM</b>	
Deep vein thrombosis (blood clot in legs)	
Anemia ("weak blood")	
HIV / AIDS	
Hepatitis (liver infection)	
Sickle cell disease	
Chronic fatigue syndrome	
Bleeding / clotting disorder ("thin" or "thick" blood)	
Leukemia / lymphoma (blood or lymph cancer)	
SLE (Lupus)	
Other:	
<b>ENDOCRINE GLANDS</b>	
Diabetes ("sugar")	
Thyroid disease (low thyroid / high thyroid)	
Cushing's disease	
Addison's disease	
Pheochromocytoma (adrenal tumor)	
Other:	
<b>SKIN</b>	
Skin cancer	
Other:	
<b>FEMALE SPECIFIC</b>	
Miscarriage / spontaneous abortion	
Currently pregnant	
Currently breastfeeding	
Breast cancer	
Uterine cancer	
Cervical cancer	
Endometriosis	
Other:	
<b>MALE SPECIFIC</b>	
Erectile dysfunction (ED)	
Prostate cancer	
Other:	
<b>MISCELLANEOUS</b>	
Motor Vehicle accident	
Whiplash injury	
Work related accident	

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- Complete the following chart to summarize your previous *surgeries* and *hospitalizations*

	Surgery / Procedure	Date Completed	Outcome / Complications	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

- Complete the following chart to summarize any known *drug allergies*, *adverse reactions* or *medications you know you can't / shouldn't take*.

	Drug	Symptoms	Mild, Moderate or Severe Reaction	Notes
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

Your Name: \_\_\_\_\_ Your Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please complete the following chart regarding your previous pertinent previous diagnostic tests / results:

Diagnostic Test / Consultation	Date Completed	Results (as YOU understand them)	Comments
CT Head			
CT Cervical Spine			
CTA Head			
CTA Neck			
MRI Brain			
MRI Cervical Spine			
MRA Head			
MRA Neck			
MRV Head			
Cerebral Angiogram			
Carotid Doppler			
CT Sinuses			
Sinus X-ray			
EEG			
Lumbar Puncture			
Temporal Artery Biopsy			
Cardiac Stress Test			
Echocardiogram			
"Bubble Study"			
Sleep Study			
Dilated Fundo. Exam			
Formal Visual Fields			
Intra-Ocular Pressure			
Food Allergy Testing			
ESR / C-Reactive Protein			
Vitamin D Level			
Thyroid Functions			
Liver Function Tests			
Catecholamine Testing			
Infectious Disease Testing			
Serum [Drug] Levels			
Urine Drug Screen			
Neuropsychometric Testing			
Other			
Other			
Other			
Consultation 1			
Consultation 2			
Consultation 3			