# Foothills Neurology, P.C. Patient History

4530 East Muirwood Drive Suite 111, Phoenix, AZ 85048 Tel: (480)961-2365 Fax: (480)961-2382

**Name: ____________________________________________ Date of appointment: __________________**

**What is the main problem you are having?**

__________________________________________________________

**Is this due to an accident? Y N Don't know Is a legal case pending? Y N Maybe**

**Age ______ DOB __________**

PLEASE LEAVE THIS BOX BLANK

| **Test / X-Ray** | **Approximate Date Done** | **Result** |
| --- | --- | --- |

***ALLERGIES*: Do you have any allergies to any medicine?_____________________________________________**

**What *MEDICINE* or *DRUG STORE PRODUCTS* are you taking?**

| **Name of Medicine** | **Dosage** | **Times per Day** | **For What** | **Approx. Date Started** |
| --- | --- | --- | --- | --- |
| • | | | | |
| • | | | | |
| • | | | | |
| • | | | | |
| • | | | | |
| • | | | | |

**Have you stopped any medicine recently or used other medicine in the past for this problem?**

**Do you take birth control pills, patch or implant? Y N What?______________________________**

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***PAST MEDICAL HISTORY*** **Do you have any other medical problems such as:**

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| | | Diabetes | | | Ulcers | | | Heart Problem |
| | | Kidney Problem | | | Hepatitis | | | Stroke |
| | | Thyroid Problem | | | Cancer | | | Arthritis |
| | | Fibromyalgia | | | Seizures | | | Asthma/Emphysem |
| | | TMJ | | | Depression | | | Anxiety |
| | | Lung Disease | | | High Cholesterol | | | Headache |
| | | Eye Disease | | | Osteoporosis | | | Chronic Pain in: |
| | | Anemia | | | High Blood Pressure | | | ☐ Back ☐ Neck ☐ Other |

**Have you had any other surgeries, hospitalizations or other medical problems? If so list them:**

**Do you have any other problems for which you have been seeing a *doctor* or *chiropractor* on a regular basis?**

***FAMILY HISTORY***

**Do you have any family members with similar problems as you? Y N**

**Do you have any family members with?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Brain Tumor | **Y** | **N** | **who?**_______________ | Stroke | **Y** | **N** | **who?**_______________ |
| Seizures | **Y** | **N** | **who?**_______________ | Heart Attack | **Y** | **N** | **who?**_______________ |
| Headaches | **Y** | **N** | **who?**_______________ | Aneurysm | **Y** | **N** | **who?**_______________ |

***SOCIAL HISTORY:***

Do you use tobacco? Y N How much? ____________________________

Do you drink alcohol? Y N How much? ____________________________

What is your occupation or major daytime activity? ________________________________________________

Have you been unable to work or carry out your usual daytime activities due to this problem?

☐ able to work ☐ have trouble working ☐ have missed some work

☐ less productive ☐ can not work ☐ have not worked since_______________

In the **past 3 months**:

how much work or school have you missed because of this problem?_________________________

how many visits to the ER, Urgent Care treatment?________________________________________

How many cups/drinks per day of: coffee_____ colas_____ tea_____ alcohol______

Do you drink diet drinks or use Nutrasweet/Equal (aspartame) or other artificial sweeteners? **Y N**

Have you ever abused drugs or alcohol? **Y N** if yes explain**:**

**If you are pregnant or thinking of getting pregnant please check here:** ☐

**(ROS)** Do you have any other symptoms that you feel are important but have not already mentioned?

| | | | |
|---|---|---|---|
| ___fever/chills | ___blurred vision | ___double vision | ___jaw pain with chewing |
| ___chest pain | ___eye pain | ___trouble urinating | ___difficulty swallowing |
| ___palpitations | ___constipation | ___diarrhea | ___shortness of breath |
| ___joint pain | ___stomach pain | ___trouble sleeping | ___excessive sweating |
| ___numbness/tingling | ___dizziness | ___swollen glands | ___**other (please explain)** |

# Foothills Neurology, P.C. — Medication History

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Name:______________________________ DOB:____________

Please Check those medications that you have **tried in the past:**

| **ANTI-INFLAMMATORIES** | **Date** | **Effectiveness** |
|---|---|---|
| ☐ Aspirin (Bayer, Ecotrin) | | |
| ☐ Ibuprofen (Motrin/Advil/Nuprin) | | |
| ☐ Naproxyn (Naprosyn/Aleve/Anaprox) | | |
| ☐ Celecoxib (Celebrex) | | |
| ☐ Diclofenac (Voltaren, Cambia) | | |
| ☐ Indomethacin (Indocin) pills or Suppos. | | |
| ☐ Ketorolac (Toradol) pills or injection | | |
| ☐ Steroids (Prednisone) | | |
| ☐ Other:____________ | | |

| **MIXED ANALGESICS(MILD PAIN)** | **Date** | **Effectiveness** |
|---|---|---|
| ☐ Butalbital (Fioricet/Esgic Plus) | | |
| ☐ Excedrine (Any form) | | |
| ☐ Tramadol (Ultram/Ultracet) | | |
| ☐ Other:____________ | | |

| **NARCOTIC PAIN MEDICINE** | **Date** | **Effectiveness** |
|---|---|---|
| ☐ Codeine | | |
| ☐ Hydrocodone (Vicodin/Lortab/Norco) | | |
| ☐ Oxycodone (Percocet/Endocet/Roxicet) | | |
| ☐ Meperidine (Demerol) pills or shots | | |
| ☐ Other:____________ | | |

| **LONG ACTING NARCOTICS** | **Date** | **Effectiveness** |
|---|---|---|
| ☐ Methadone (Dolphine, Methadose) | | |
| ☐ OxyContin | | |
| ☐ MS Contin (Avinza/Kadian/MSIR) | | |
| ☐ Fentanyl Patch (Duragesic Patch) | | |
| ☐ Hydromorphone (Exalgo, Dilaudid) | | |
| ☐ Other:____________ | | |

| **MUSCLE RELAXANTS** | **Date** | **Effectiveness** |
|---|---|---|
| ☐ Baclofen (Lioresal) | | |
| ☐ Cyclobenzaprine (Flexeril, Amrix) | | |
| ☐ Tizanidine (Zanaflex) | | |
| ☐ Other:____________ | | |

| **ALTERNATIVE TREATMENTS** | **Date** | **Effectiveness** |
|---|---|---|
| ☐ Botulinum Toxin (Botox) | | |
| ☐ Lidocaine 5% (Lidoderm Patch) | | |
| ☐ IV Therapy for Migraine | | |
| ☐ Acupuncture | | |
| ☐ Trigger Point Injections | | |
| ☐ Nerve blocks(occipital/neck/back) | | |
| ☐ Physical Therapy | | |
| ☐ Massage | | |
| ☐ Oxygen | | |
| ☐ Vitamins/Minerals (B, D, Magnesium) | | |
| ☐ Biofeedback ☐ Meditation | | |
| ☐ Ice/Heat | | |
| ☐ Other:____________ | | |
| ☐ Other:____________ | | |
| ☐ Other:____________ | | |

| **MIGRAINE MEDICINES** | **Date** | **Effectiveness** |
|---|---|---|
| ☐ Sumatriptan (Imitrex/Treximet) | | |
| (pills/shot/nasal spray) | | |
| ☐ Rizatriptan (Maxalt) | | |
| ☐ Eletriptan (Relpax) | | |
| ☐ Frovatriptan (Frova) | | |
| ☐ Zolmitriptan (Zomig) | | |
| ☐ Naratriptan (Amerge) | | |
| ☐ Almotriptan (Axert) | | |
| ☐ Dihydroergotamine (DHE/Migranal) | | |

| **ANTICONVULSANTS** | **Date** | **Duration Tx** | **Effectiveness** |
|---|---|---|---|
| ☐ Valproic acid (Depakote) | | | |
| ☐ Zonisamide (Zonagran) | | | |
| ☐ Gabapentin (Neurontin) | | | |
| ☐ Oxcarbazepine (Trileptal) | | | |
| ☐ Lamotrigene (Lamictal) | | | |
| ☐ Levetiracetam (Keppra) | | | |
| ☐ Topiramate (Topamax) | | | |
| ☐ Pregabalin (Lyrica) | | | |
| ☐ Tiagabine (Gabitril) | | | |
| ☐ Lacosamide (Vimpat) | | | |
| ☐ Other: ____________ | | | |

| **TRICYLIC ANTIDEPR** | **Date** | **Duration Tx** | **Effectiveness** |
|---|---|---|---|
| ☐ Amitriptyline (Elavil) | | | |
| ☐ Nortriptyline (Pamelor) | | | |
| ☐ Doxepin (Sinequan) | | | |
| ☐ Trazodone (Desyrel) | | | |
| ☐ Other:____________ | | | |

| **SRI/DOPA INHIBITORS** | **Date** | **Duration Tx** | **Effectiveness** |
|---|---|---|---|
| ☐ Bupropion (Wellbutrin) | | | |
| ☐ Venlafaxine (Effexor) | | | |
| ☐ Milnacipran (Savella) | | | |
| ☐ Duloxetine (Cymbalta) | | | |
| ☐ Other:____________ | | | |

| **BETA BLOCKERS** | **Date** | **Duration Tx** | **Effectiveness** |
|---|---|---|---|
| ☐ Propranolol (Inderal) | | | |
| ☐ Atenolol (Tenormin) | | | |
| ☐ Nadolol (Corgard) | | | |
| ☐ Metoprolol (Lopressor) | | | |
| ☐ Other:____________ | | | |

| **CALCIUM BLOCKERS** | **Date** | **Duration Tx** | **Effectiveness** |
|---|---|---|---|
| ☐ Verapamil (Calan,Veralan) | | | |
| ☐ Nicardipine(Cardene) | | | |
| ☐ Other:____________ | | | |

**ALLERGIES: Medication & Reaction**

______________________________

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______________________________

# The Migraine Disability Assessment Test

The MIDAS (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

## INSTRUCTIONS

Please answer the following questions about ALL of the headaches you have had over the past 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your healthcare professional.

____ 1. On how many days in the last 3 months did you miss work or school because of your headaches?

____ 2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

____ 3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

____ 4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

____ 5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

____ Total (Questions 1-5)

**What your Physician will need to know about your headache:**

____ A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.)

____ B. On a scale of 0 - 10, on average how painful were these headaches? (where 0=no pain at all, and 10=pain as bad as it can be.)

**Scoring:** After you have filled out this questionnaire, add the total number of days from questions 1-5 (ignore A and B).

| MIDAS Grade | Definition | MIDAS Score |
|---|---|---|
| I | Little or No Disability | 0-5 |
| II | Mild Disability | 6-10 |
| III | Moderate Disability | 11-20 |
| IV | Severe Disability | 21+ |

**If Your MIDAS Score is 6 or more, please discuss this with your doctor.**

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