New Patient Information Form

As a new patient to the Headache Center at Dartmouth-Hitchcock Medical Center, we ask that you please fill out the following questionnaire. If you print this out ahead of time, please bring in the completed form with you to your appointment.

Your name:______________________________________ Date:________________

Your primary care physician’s name:_____________________________________

At what age did your headaches begin?________ Where is the pain?________

Please describe the pain:_________________________________________________

Do you have any symptoms that happen before you get a headache? If yes, please describe: _____________________________________________________________

When you have a headache, what symptoms do you have along with the headache pain?_________________________________________________________

What time of day do you usually develop a headache?______________________

How many mild headache days do you have each week?_____________________

How many severe headache days do you have each week?___________________

List ALL of the medications you are taking now:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

What medications have you tried in the past for your headaches? Please list:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Are there things that trigger your headaches? Please list:____________________

____________________________________________________________________

Do you have any history in your family of headaches or neurologic conditions?
____________________________________________________________________
Have you had any head or neck injuries? Please list and describe:

________________________________________________________________________

Please list all of your medical conditions and any surgeries you have had:

________________________________________________________________________

*Please list amounts of:*
- Tobacco (cigarettes or other tobacco products used per day): __________
- Alcohol (per week): __________
- Caffeine (cups per day): __________
- Exercise (hours per week/type): ___________________________________________________________________

What is your occupation? ________________________________________________________________________

Are you missing work because of your headaches? ______

Please describe your mood (ex: anxious, depressed, good): __________________________________________________________________

Do you have any history of abuse? (physical, emotional, sexual, childhood):

________________________________________________________________________

*Please answer yes or no to these questions:*
- How many hours do you sleep during the night? ______
- Do you take naps during the day? ______
- Do you have difficulty falling asleep or staying asleep? ______
- Do you have frequent nightmares? ______
- Do you ever stop breathing in your sleep? ______
- Do you snore? ______
- Have you had any x-rays, CAT scans or MRI imaging studies of your head or neck?
  If yes, please list what you’ve had done and approximately when:

________________________________________________________________________

If you are a female:
- When was your last menstrual period? __________________________________________________________________
- What form of contraception do you use? __________________________________________________________________

*Please explain what your goals are for your first visit to the Headache Center:*

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Thank you for choosing the Headache Center for your care. We look forward to working with you to meet your goals!