Dartmouth-Hitchcock

DEPARTMENT OF NEUROLOGY | Headache Center

Dartmouth-Hitchcock Medical Center
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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!