



excellence in brain, spine and pain care

neurosciencegroup

YOUR MEDICAL HISTORY

HEADACHE RELATED MEDICATIONS AND TREATMENTS

Please check the medications you have tried since headaches first began.

Please star the medications that have helped reduce headache.

ANTICONVULSANTS:	ANTIDEPRESSANTS continued:
<input type="checkbox"/> Carbamazepine (TEGRETOL)	<input type="checkbox"/> Tranylcypromine (PARNATE)
<input type="checkbox"/> Gabapentin (NEURONTIN)	<input type="checkbox"/> Trazodone (DESYREL)
<input type="checkbox"/> Lamotrigine (LAMICTAL)	<input type="checkbox"/> Venlafaxine (EFFEXOR)
<input type="checkbox"/> Levetiracetam (KEPPRA)	<input type="checkbox"/> Other:
<input type="checkbox"/> Oxcarbamazepine (TRILEPTAL, CARBITROL)	<input type="checkbox"/> Other:
<input type="checkbox"/> PHENOBARBITOL	ANTI HISTAMINES:
<input type="checkbox"/> Phenytoin (DILANTIN)	<input type="checkbox"/> Cyproheptadine (PERIACTIN)
<input type="checkbox"/> Pregabalin (LYRICA)	<input type="checkbox"/> Diphenhydramine (BENADRYL)
<input type="checkbox"/> Primidone (MYSOLINE)	<input type="checkbox"/> Hydroxyzine (VISTARIL, ATARAX)
<input type="checkbox"/> Tiagabine (GABITRIL)	<input type="checkbox"/> Meclizine (ANTIVERT)
<input type="checkbox"/> Topiramate (TOPOMAX)	<input type="checkbox"/> Orphenadrine (NORFLEX)
<input type="checkbox"/> Trokendi XR (Topiramate extended release)	<input type="checkbox"/> Other:
<input type="checkbox"/> Valproate (DEPAKOTE)	<input type="checkbox"/> Other:
<input type="checkbox"/> Zonisamide (ZONEGRAN)	
<input type="checkbox"/> Other:	ANTI HYPERTENSIVE/Blood Pressure:
<input type="checkbox"/> Other:	<input type="checkbox"/> Amlodipine (NORVASC)
<input type="checkbox"/> Other:	<input type="checkbox"/> Atenolol (TENORMIN)
	<input type="checkbox"/> Benazepril (LOTENSIN)
ANTIDEPRESSANTS:	<input type="checkbox"/> Bisoprolol (ZEBETA)
<input type="checkbox"/> Amitriptyline (ELAVIL)	<input type="checkbox"/> Captopril (CAPOTEN)
<input type="checkbox"/> Amoxapine (ASENDIN)	<input type="checkbox"/> Candesartan (ATACAND)
<input type="checkbox"/> Bupropion (WELLBUTRIN, ZYBAN)	<input type="checkbox"/> Clonidine (CATAPRES)
<input type="checkbox"/> Citalopram (CELEXA)	<input type="checkbox"/> Diltiazem (CARDIZEM)
<input type="checkbox"/> Clomipramine (ANAFRANIL)	<input type="checkbox"/> Enalapril (VASOTEC)
<input type="checkbox"/> Desipramine (NORPAMIN)	<input type="checkbox"/> Eprosartan (TEVETEN)
<input type="checkbox"/> Desvenlafaxine (PRISTIQ)	<input type="checkbox"/> Flunarizine (SIBELIUM)
<input type="checkbox"/> Doxepin (SINEQUAN)	<input type="checkbox"/> Irbesartan (AVAPRO)
<input type="checkbox"/> Duloxetine (CYMBALTA)	<input type="checkbox"/> Lisinopril (PRINIVIL, ZESTRIL)
<input type="checkbox"/> Fluoxetine (PROZAC)	<input type="checkbox"/> Losartan (COZAAR)
<input type="checkbox"/> Fluvoxamine (LUVOX)	<input type="checkbox"/> Metoprolol (LOPRESSOR, TOPROL)
<input type="checkbox"/> Imipramine (TOFRANIL)	<input type="checkbox"/> Nadolol (CORGARD)
<input type="checkbox"/> Maprotiline (LUDIOMIL)	<input type="checkbox"/> Nifedipine (PROCARDIA)
<input type="checkbox"/> Milnacipran (SAVELLA)	<input type="checkbox"/> Nisoldipine (SULAR)
<input type="checkbox"/> Mirtazapine (REMERON)	<input type="checkbox"/> Nimodipine (NIMOTOP)
<input type="checkbox"/> Nefazodone (SERZONE)	<input type="checkbox"/> Propranolol (INDERAL)
<input type="checkbox"/> Nortriptyline (PAMELOR)	<input type="checkbox"/> Telmisartan (MICARDIS)
<input type="checkbox"/> Paroxetine (PAXIL)	<input type="checkbox"/> Timolol (BLOCADREN)
<input type="checkbox"/> Phenelzine (NARDIL)	<input type="checkbox"/> Valsartan (DIOVAN)
<input type="checkbox"/> Protriptyline (VIVACTIL)	<input type="checkbox"/> Verapamil (CALAN, VERELAN)
<input type="checkbox"/> Escitalopram (LEXAPRO)	<input type="checkbox"/> Other:
<input type="checkbox"/> Sertraline (ZOLOFT)	



<u>ANTINAUSEANTS:</u>	<u>LEUKOTRIENE ANTAGONISTS:</u>
<input type="checkbox"/> Alosetron (LOTRONEX)	<input type="checkbox"/> Montelukast (SINGULAIR)
<input type="checkbox"/> Alprazolam (XANAX)	<input type="checkbox"/> Zafirlukast (ACCOLATE)
<input type="checkbox"/> Buspirone (BUSPAR)	<input type="checkbox"/> Zileuton (ZIFLO)
<input type="checkbox"/> Clorazepate (TRANXENE)	<input type="checkbox"/> Other:
<input type="checkbox"/> Chlordiazepoxide (LIBRIUM)	
<input type="checkbox"/> Clonazepam (KLONOPIN)	<u>MUSCLE RELAXANTS:</u>
<input type="checkbox"/> Diazepam (VALIUM)	<input type="checkbox"/> Baclofen (LIORESAL)
<input type="checkbox"/> Flurazepam (DALMANE)	<input type="checkbox"/> Carisoprodol (SOMA)
<input type="checkbox"/> Lorazepam (ATIVAN)	<input type="checkbox"/> Chlorzoxazone (PARAFON FORTE)
<input type="checkbox"/> Midazolam (VERSED)	<input type="checkbox"/> Cyclobenzaprine (FLEXERIL, AMRIX)
<input type="checkbox"/> Oxazepam (SERAX)	<input type="checkbox"/> Metaxalone (SKELAXIN)
<input type="checkbox"/> Temazepam (RESTORIL)	<input type="checkbox"/> Methocarbamol (ROBAXIN)
<input type="checkbox"/> Triazolam (HALCION)	<input type="checkbox"/> Orphenadrine (NORFLEX)
<input type="checkbox"/> Zolpidem (AMBIEN)	<input type="checkbox"/> Tizanidine (ZANAFLEX)
	<input type="checkbox"/> Other:
	<input type="checkbox"/> Other:
<u>ATYPICAL NEUROLEPTICS:</u>	
<input type="checkbox"/> Aripiprazole (ABILIFY)	
<input type="checkbox"/> Olanzapine (ZYPREXA)	<u>NEUROTOXINS:</u>
<input type="checkbox"/> Quetiapine (SEROQUEL)	<input type="checkbox"/> BOTOX (Type A)
<input type="checkbox"/> Risperidone (RESPERDAL)	<input type="checkbox"/> DYSPORT (Type A)
<input type="checkbox"/> Ziprasidone (GEODON)	<input type="checkbox"/> MYOBLOC (Type B)
<input type="checkbox"/> Other:	
	<u>NMDA Glutamate Antagonists</u>
<u>ERGOTS:</u>	<input type="checkbox"/> Dextromethorphan
<input type="checkbox"/> Bromocriptine (PARLODEL)	<input type="checkbox"/> Ketamine
<input type="checkbox"/> DHE (D.H.E. – 45, MIGRANAL, LEVADEX)	<input type="checkbox"/> Memantine (NAMENDA)
<input type="checkbox"/> Ergonovine/Ergometrine	<input type="checkbox"/> Other:
<input type="checkbox"/> Ergotamine (CAFERGOT)	
<input type="checkbox"/> Methylergonovine/Methylergometrine (METHERGINE)	<u>OPIOIDS/NARCOTICS:</u>
<input type="checkbox"/> Methysergide (SANSERT)	<input type="checkbox"/> Buprenorphine (SUBUTEX)
<input type="checkbox"/> Other:	<input type="checkbox"/> Buprenorphine/Naloxone (SUBOXONE)
	<input type="checkbox"/> Butorphanol (STADOL)
<u>SEROTONIN-2 ANTAGONISTS:</u>	<input type="checkbox"/> Codeine
<input type="checkbox"/> Cyproheptadine (PERIACTIN)	<input type="checkbox"/> Fentanyl (DURAGESIC)
<input type="checkbox"/> Pizotifen (SANDOMIGRAN)	<input type="checkbox"/> Hydrocodone (LORCET, LORTAB, NORCO, VICODIN XODOL, ZYDONE)
	<input type="checkbox"/> Hydromorphone (DILAUDID)
<u>STEROIDS:</u>	<input type="checkbox"/> Levorphanol (LEVODROMERAN)
<input type="checkbox"/> Dexamethasone (DECADRON)	<input type="checkbox"/> Meperidine (DEMEROL)
<input type="checkbox"/> Methylprednisolone (MEDROL DOSEPAK, SOLUMEDROL)	<input type="checkbox"/> Methadone
<input type="checkbox"/> Prednisone	<input type="checkbox"/> Morphine
<u>SLEEPERS:</u>	<input type="checkbox"/> Oxycodone (PERCOCET, OXYIR)
<input type="checkbox"/> Eszopiclone (LUNESTA)	<input type="checkbox"/> Oxymorphone (OPANA)
<input type="checkbox"/> Melatonin	<input type="checkbox"/> Pentazocine (TALWIN)
<input type="checkbox"/> Ramelteon (ROZEREM)	<input type="checkbox"/> Propoxyphene (DARVON)
<input type="checkbox"/> Zaleplon (SONATA)	<input type="checkbox"/> Tramadol (ULTRAM)
<input type="checkbox"/> Other:	



<u>BENZODIAZEPINES/MILD TRANQUILIZERS:</u>	<u>CGRP MONOCLONAL ANTIBODIES:</u>
<input type="checkbox"/> Alprazolam (XANAX)	<input type="checkbox"/> Erenumab (AIMOVIG)
<input type="checkbox"/> Buspirone (BUSPAR)	<input type="checkbox"/> Fremanezumab (AJOVY)
<input type="checkbox"/> Clorazepate (TRANXENE)	<input type="checkbox"/> Galcanezumab (EMGALITY)
<input type="checkbox"/> Chlordiazepoxide (LIBRIUM)	
<input type="checkbox"/> Clonazepam (KLONOPIN)	<u>MISCELLANEOUS</u>
<input type="checkbox"/> Diazepam (VALIUM)	<input type="checkbox"/> Acetaminophen (TYLENOL)
<input type="checkbox"/> Flurazepam (DALMANE)	<input type="checkbox"/> ANACIN
<input type="checkbox"/> Lorazepam (ATIVAN)	<input type="checkbox"/> Butalbital (ESGIC, FLORINAL/CET, PHRENILIN)
<input type="checkbox"/> Midazolam (VERSED)	<input type="checkbox"/> Isometheptene/Dichloralphenazone/APAP (MIDRIN, DURADRIN)
<input type="checkbox"/> Oxazepam (SERAX)	<input type="checkbox"/> Lithium
<input type="checkbox"/> Temazepam (RESTORIL)	
<input type="checkbox"/> Triazolam (HALCION)	<u>ANTI-INFLAMMATORIES/COX-2 INHIBITOR:</u>
<input type="checkbox"/> Zolpidem (AMBIEN)	<input type="checkbox"/> Celecoxib (CELEBREX)
	<input type="checkbox"/> Etoricoxib (ARCOXIA)
<u>TRIPTANS:</u>	<input type="checkbox"/> Rofecoxib (VIOXX)
<input type="checkbox"/> Almotriptan (ACERT, ALMOGRAN)	<input type="checkbox"/> Valdecoxib (BEXTRA)
<input type="checkbox"/> Eletriptan (RELPAX)	
<input type="checkbox"/> Frovatriptan (FROVA)	<u>ANTI-INFLAMMATORIES/NON-STEROIDAL/NSAID'S:</u>
<input type="checkbox"/> Naratriptan (AMERGE, NARAMIG)	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Rizatriptan (MAXALT) – oral/ODT	<input type="checkbox"/> Diclofenac (CAMBIA, CATAFLAM, FLECTOR, VOLTAREN)
<input type="checkbox"/> Sumatriptan (IMITREX) oral/ injectable/NS	<input type="checkbox"/> Etodolac (LODINE)
<input type="checkbox"/> Sumatriptan/Naproxen Sodium (Treximet)	<input type="checkbox"/> Excedrin
<input type="checkbox"/> Zolmitriptan (ZOMIG) oral/NS	<input type="checkbox"/> Flurbiprofen (ANSAID)
<input type="checkbox"/> Other:	<input type="checkbox"/> Idomethacin (INDOCIN)
<input type="checkbox"/>	<input type="checkbox"/> Ibuprofen (ADVIL, MOTRIN)
<u>NON-DRUG/BEHAVIORAL TREATMENTS:</u>	<input type="checkbox"/> Ketoprofen (ORUDIS, ORUVAIL)
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Ketorolac (TORADOL)
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Meclofenamate (MECLOMEN)
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Mefenamic Acid (PONSTEL)
<input type="checkbox"/> Heat/Cold	<input type="checkbox"/> Meloxicam (MOBIC)
<input type="checkbox"/> Massage Therapy	<input type="checkbox"/> Nabumetone (RELAFEN)
<input type="checkbox"/> Nerve Blocks	<input type="checkbox"/> Naproxen/Naproxen Sodium (ALEVE, ANAPROX, NAPRELAN, NAPROSYN)
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Piroxicam (FELDENE)
<input type="checkbox"/> Sleep/Quiet	<input type="checkbox"/> Sulindac (CLINORIL)
<input type="checkbox"/> Stimulator	<input type="checkbox"/> Other:
<input type="checkbox"/> Surgery/Ablation	
<input type="checkbox"/> Trigger Point Injections	<u>HERB, MINERAL, VITAMIN, SUPPLEMENT & OTC'S:</u>
<input type="checkbox"/> SPG Blocks	<input type="checkbox"/> Coenzyme Q10
<input type="checkbox"/> External Trigeminal Nerve Stimulation Device (Cefaly)	<input type="checkbox"/> Feverfew
<input type="checkbox"/> Non-invasive Vagus Nerve Stimulation (gammaCore)	<input type="checkbox"/> Magnesium
<input type="checkbox"/> Sensory deprivation tank, room or pod	<input type="checkbox"/> Melatonin
	<input type="checkbox"/> Oxygen
	<input type="checkbox"/> Petasites/Butterbur Root (PETADOXEX)
	<input type="checkbox"/> Riboflavin/Vitamin B2



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STIMULANTS:	OTHER MEDICATIONS/TREATMENTS:
<input type="checkbox"/> Albuterol (PROVENTIL, VENTOLIN, VOLMAX, VOSPIRE)	<input type="checkbox"/> Other:
<input type="checkbox"/> Atomoxetine (STRATTERA)	<input type="checkbox"/> Other:
<input type="checkbox"/> Benzphetamine (DIDRX)	<input type="checkbox"/> Other:
<input type="checkbox"/> Caffeine	<input type="checkbox"/> Other:
<input type="checkbox"/> Dexmethylphenidate (FOCALIN)	<input type="checkbox"/> Other:
<input type="checkbox"/> Dextroamphetamine (DEXADRINE, ADDERALL)	<input type="checkbox"/> Other:
<input type="checkbox"/> Methylphenidate (CONCERTA, METADATE, RITALIN)	<input type="checkbox"/> Other:
<input type="checkbox"/> Nicotine	<input type="checkbox"/> Other:
<input type="checkbox"/> Yohimbine	<input type="checkbox"/> Other:

CAFFEINE USE:

How much per day? _____

BIRTH CONTROL PILLS or OTHER FORMS OF ESTROGEN: Yes _____ No _____

Any recent change? _____

History of Motion Sickness? Yes _____ No _____

Family History of Head pain? Yes _____ No _____

If female, history of menstrual head pain? Yes _____ No _____

Average hours of sleep per night? _____

Weight stable? Yes _____ No _____ If not how much over how long have you lost or gained? _____

Exercising? Yes _____ No _____ How often and for how long? _____

Stress? Yes _____ No _____ If yes, what is the cause? _____

Missing work, school or other responsibilities? Yes _____ No _____ How often? _____

Any related testing: Yes _____ No _____ Describe any related testing: _____

