NEW YORK HEADACHE CENTER

General Medical History:

Do you now have, or have you ever had, any of the following:

- ❑ Head or neck injury, even if minor, including "whiplash". Describe (include dates):
- ❑ Loss of consciousness
- ❑ Brain infection
- ❑ Seizures
- ❑ High blood pressure
- ❑ Palpitations
- ❑ Chest pain
- ❑ Other heart disease
- ❑ Kidney disease
- ❑ Urinary tract infection
- ❑ Asthma
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Sinus problems
- ❑ Birth abnormality
- ❑ Skin spots
- ❑ Ulcers
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Diabetes Mellitus
- ❑ Abnormal blood sugar.
- ❑ Thyroid disease
- ❑ Recent weight change
- ❑ Frequent infections
- ❑ Cold sores (fever blisters) on the lips or the mouth.
- ❑ Arthritis/joint pain.
- ❑ Skin rash
- ❑ Anemia
- ❑ Blood/bleeding/clotting problems
- ❑ Bruising
- ❑ Depression
- ❑ Anxiety
- ❑ Panic attacks
- ❑ Other psychiatric problem
- ❑ Cancer or tumor of any part of the body
- ❑ Motion sickness
- ❑ Vertigo/dizziness
- ❑ Lyme Disease
- ❑ Chronic Fatigue
- ❑ Fibromyalgia
- ❑ Epstein Barr
- ❑ Teeth grinding or clenching
- ❑ Allergies. Describe:
- ❑ Any other condition for which you are under medical care? Explain:
- ❑ Any surgery. Explain, with dates:
- ❑ Unusual childhood illnesses. Explain:

Please list all prescription pills you now take for any medical condition (including birth control pills):
……

Please list any pills you take that do not require a prescription (vitamins, Tylenol, cold medicines, herbal supplements, etc.): ……

Sleep History:

How many hours do you sleep each night: ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ variable
What time do you physically get into bed at night:…….. Every night?: ❑ Yes ❑ No.
What time do you get up in the morning:…….. Every morning?: ❑ Yes ❑ No.
How many minutes does it take you to fall asleep:…….
How deep is your sleep: ❑ light ❑ medium ❑ heavy
Do you awaken refreshed: ❑ Yes ❑ No.
Are you sleepy during the day or evening (do you fall asleep if inactive, ex. watching TV): ❑ Yes ❑ No.
Have you ever had any unusual sleep-related problems, in childhood or as an adult: ❑ Yes ❑ No.
Do you snore: ❑ Yes ❑ No.
Do you awaken during the night: ❑ Yes ❑ No.
Do you have irritating feeling in your legs when relaxing, trying to fall asleep, or on long trips: ❑ Yes ❑ No.
Does anyone in your family have sleeping problems of any sort: ❑ Yes ❑ No.
If yes, describe: ……