Stanford Children's Health

Supplementary Form for Headaches

This information will become part of the patient's permanent records, and as with all information, will remain confidential. Please fill out as accurately as possible.

Child's name: _____ DOB: _____

Please indicate when the headaches started: _____

How frequently do the headaches occur? _____

Where are the headaches located? *(Please be specific):* _____

How long do the headaches last? _____

Please rate the average severity of the headaches, with "10" being most severe (circle one):

1 2 3 4 5 6 7 8 9 10

Have you ever been to the emergency room for pain control? ☐ No ☐ Yes

What seems to help the headaches?

Please indicate whether the patient has the following symptoms before, during or after the headache:

Y	N	Symptom	Y	N	Symptom	Y	N	Symptom
☐	☐	Sensitivity to light	☐	☐	Abdominal pain/cramping	☐	☐	Dizziness
☐	☐	Sensitivity to sound	☐	☐	Visual changes	☐	☐	Unsteady gait
☐	☐	Nausea	☐	☐	Numbness or tingling	☐	☐	Sleepiness
☐	☐	Vomiting	☐	☐	Weakness	☐	☐	Irritability

Please list any additional symptoms or details of those indicated above:

Please list all medications tried:

√	Medication	√	Medication
☐	Tylenol (Acetaminophen)	☐	Zomig (zolmitriptan) oral tablets
☐	Advil/Motrin (Ibuprofen)	☐	Zomig (zolmitriptan) meltable wafers
☐	Aspirin (acetylsalicylic acid)	☐	Zomig (zolmitriptan) nasal spray
☐	Excedrin	☐	Maxalt (rizatriptan) oral tablets
☐	Aleve (Naprosyn)	☐	Maxalt (rizatriptan) meltable wafers
☐	Indocin (indomethicin)	☐	Amerge (naratriptan)
☐	Toradol (Ketoralac)	☐	Axert (Almotriptan)
☐	Fiorinal (ASA, butalbital, caffeine)	☐	Frova (Frovatriptan)
☐	Esgic or Fioricet (acetaminophen, butalbital,caffeine)	☐	Relpax (Eletriptan)
☐	Esgic plus (Tylenol, butalbital, caffeine)	☐	Phenergan (promethazine)
☐	Phrenilin (Acetaminophen, butalbital)	☐	Compazine (prochlorperizine)
☐	Phrenilin Forte (Acetaminophen, butalbital)	☐	Zofran (odansetron)
☐	Midrin (Isometheptene, acetaminophen, dichoralphenazone)	☐	Depakot (Valproic Acid)
☐	Tyco (Tylenol with codeine)	☐	Inderal (propanolol)
☐	Demerol (Meperidine)	☐	Elavil (amitriptyline)
☐	Oxycodone	☐	Norpramin (desipramine)
☐	Morphine	☐	Pamelor (nortriptyline)
☐	Stadol (intranasal butorphanol)	☐	Neurontin (gabapentin)
☐	Cafergot/Ergomar (ergotamine citrate)	☐	Lyrica (pregabalin)
☐	Migranal (dihydroergotamine nasal spray)	☐	Topamax (Topiramate)
☐	D.H.E. 45 (dihdroergotamine IV)	☐	Verapamil
☐	Imitrex (Sumatriptan) subcutaneous injections	☐	Periactin (cyproheptidine)
☐	Imitrex (sumatriptan) nasal spray	☐	Zanaflex (tizanidine)
☐	Imitrex (sumatriptan) oral tablets	☐	Other:
☐	Other:	☐	Other:
☐	Other:	☐	Other:

Please indicate known triggers for the headaches:

√	Triggers	√	Medication
☐	Lack of sleep	☐	Foods:
☐	Stress	☐	Foods:
☐	Heat and/or dehydration	☐	Foods:
☐	Exertion/physical activity	☐	Other:
☐	Bright lights/florescent lights	☐	Other:
☐	Loud background noises	☐	Other:
☐	Overstimulation	☐	Other:
☐	Skipping meals	☐	Other:

Have you tried any of the following treatments for the patient's headaches?

√	Treatment
☐	Biofeedback training
☐	Acupuncture
☐	Herbs or supplements:
☐	Chiropractic work
☐	Meditation training
☐	Counseling

Has the patient missed school, work, or important activities because of headaches? ☐ No ☐ Yes

If yes, how often and for how many days?

Is there anyone in the family who gets headaches or has a known migraine disorder? ☐ No ☐ Yes

If yes, please list:

Has the patient ever had an MRI scan or CT? ☐ No ☐ Yes

If yes, please indicate location:

Has the patient seen any other neurologist(s) for the headaches? ☐ No ☐ Yes

If yes, please list names:

Signature: Date:

Thank you for taking your time to complete this form. We look forward to meeting you and your child at his/her appointment.