Northeastern Migraine
SURGERY CENTER
a division of Bangor Plastic and Hand Surgery

**General Patient Information**

**Dr. David A. Branch, M.D.**

****Please Print****

Patient Name: _____

Date of Birth: _____ Social Security # _____

Email Address: _____

Patient Address: _____

City: _____State: _____ Zip Code: _____

Phone: _____ Marital Status: __S __M __W __D

Emergency Contact: _____Emergency Contact Phone: _____

Referring Physician: _____Phone Number: _____

Address: _____

Primary Care Physician: _____Phone Number: _____

Address: _____

Neurologist: _____Phone Number: _____

Address: _____

Name of Insurance Company: _____

Address: _____

Policy Number: _____Group Number: _____

Provider / Customer phone number from back of card: _____

Secondary Insurance: _____

Address: _____

Policy Number: _____Group Number: _____

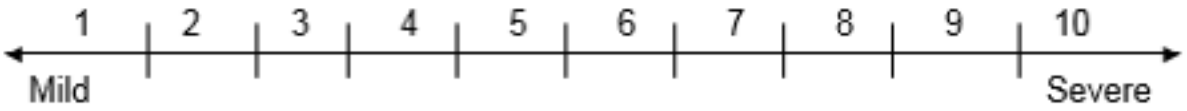
Provider /Customer phone number from back of card: _____

1. How many **migraine** headaches do you experience per month?_____

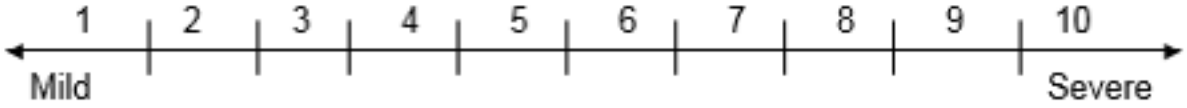
2. How many **regular** headaches do you experience per month?_____

3. How long do your migraine headaches usually last (in hours) ? _____

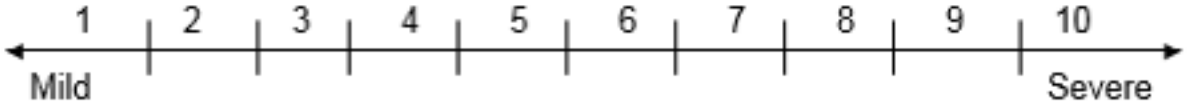
4. How painful are your headaches **<u>on average</u>**? (circle one number)



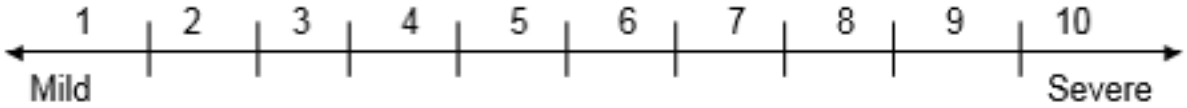

5. What is the **<u>worst</u>** headache that you experience regularly? (circle one number)




6. What is the **<u>mildest</u>** headache that you experience regularly? (circle one number)




7. What is your headache score **<u>today</u>**? (circle one number)




8. Does your headache score actually ever go to zero? ☐ YES ☐ NO

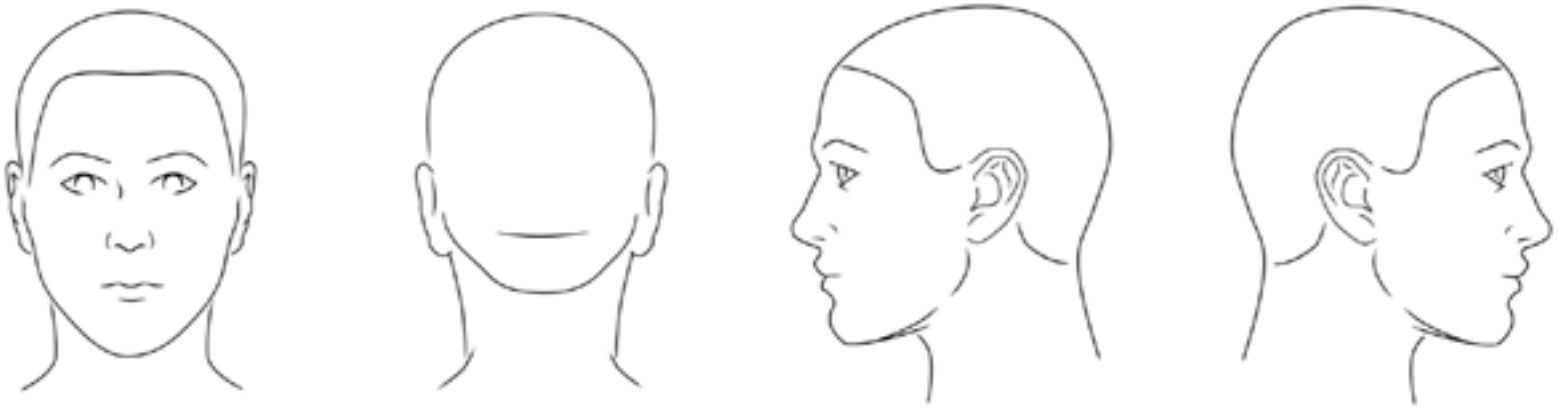
9. On which side of the head is your pain?
   ☐ right side ☐ left side ☐ both sides

10. Is your pain more prominent on the right side, the left side, or equal on both sides?
    ☐ right side ☐ left side ☐ both sides

11. Where do your migraine headaches usually **START**? (check all that apply)

| | | |
|---|---|---|
| ☐ Behind right eye | ☐ Behind left eye | ☐ Behind both eyes |
| ☐ Right temple | ☐ Left temple | ☐ Both temples |
| ☐ Above right eyebrow | ☐ Above left eyebrow | ☐ Above both eyebrows |
| ☐ Back of head on right | ☐ Back of head on left | ☐ Back of head on both sides |
| ☐ Nose / center of face | ☐ Other: Please describe _____ | |

12. Please draw where the pain starts and where it spreads. Use X for where it starts or is more severe, and arrows for where it spreads.



13. How old were you when your **migraine** headaches started? _____

14. Was there any event that you believe caused/started your migraines?

☐ YES ☐ NO

If yes, what event? _____

15. Have you ever had a **head or neck injury** (e.g. whiplash, concussion)? ☐ YES ☐ NO

a. If yes, please describe: _____

_____

16. Do you or one of your physicians suspect that a health disorder is somehow related to your migraine headaches?

☐ YES ☐ NO

a. If yes, please describe: _____

_____

17. How would you describe the pain associated with your migraine headaches? (check all that apply)

| | |
|---|---|
| ☐ Throbbing or pounding | ☐ Other |
| ☐ Aching or pressure | ☐ Tightness |
| ☐ Dull pain | |

18. Do your migraine headaches wake you up at night?

☐ Never ☐ Occasionally ☐ Often

19. Do any of the following occur before or during your migraine headaches? (check all that apply)

| | | |
|---|---|---|
| ☐Nausea | ☐Vomiting | ☐Diarrhea |
| ☐Bothered by light/noise | ☐Blurred/double vision | ☐Sparkling, flashing, or colored lights |
| ☐Eyelid puffy | ☐Eyelid drooping | ☐Loss of vision |
| ☐Lightheadedness | ☐Numbness / tingling | ☐Weakness of arm or leg |
| ☐Difficulty concentrating | ☐Speech difficulty | ☐Loss of consciousness |
| ☐Runny nose | ☐Other:_____ | |

20. Do any of the following trigger your migraine headaches or make them worse? (check all that apply)

| | | |
|---|---|---|
| ☐Stress (worry, anger) | ☐Bright sunshine | ☐Weather change |
| ☐Letdown after stress | ☐Loud noise | ☐Heavy lifting |
| ☐Air travel | ☐Fatigue | ☐Certain smells or perfume |
| ☐Missed meals | ☐Sexual activity | ☐Coughing, straining, bending over |
| ☐Certain foods (chocolate, cheese, beer, MSG) | | ☐Other: _____ |

21. Do any of the following make your migraine headaches better?

| | | |
|---|---|---|
| ☐Rest | ☐Exercise | ☐Quiet and darkness |
| ☐Hot or cold compress | ☐Massage | ☐Warm shower |
| ☐Pressure over migraine headache area | | ☐Other: _____ |

22. If you are female, do your migraine headaches change with the following? (check all that apply)

| | |
|---|---|
| ☐Menstrual periods | ☐Pregnancy |
| ☐Birth control pills | ☐Other hormonal drugs |

If yes, have the conditions mentioned above made your migraines better or worse?

☐ Better ☐ Worse

23. a. How many neurologists have you seen for your migraines? _____

Please list their names: _____

_____

_____

_____

_____

b. What was the diagnosis? (check all that apply)

☐ Migraine ☐ Tension-Headache ☐ Cluster ☐ Occipital Neuralgia

☐ Trigeminal Neuralgia ☐ Chronic Migraine ☐ Episodic Migraine ☐ Cervicogenic Headache

☐Other: _____

24. Have you had any of the following **radiology studies** performed?

a. MRI (Head): ☐ YES ☐ NO
   i. If yes, date of study: _____
b. MRI (Neck): ☐ YES ☐ NO
   i. If yes, date of study: _____
c. CT Scan (Head/Neck): ☐ YES ☐ NO
   i. If yes, date of study: _____
d. Other ☐ YES ☐ NO
   i. If yes, type and date of study: _____

***If you answered yes to any of the radiology studies, please bring copy of reports to your appointment***

25. Please list **current** medications you are taking to treat your migraine headaches:

a. Preventative (Prophylactic):

b. Rescue (Abortive):

26. Please check any **past medications** you have taken to treat your migraine headaches:

a. Anti-inflammatory:

| | | | |
|---|---|---|---|
| ☐ Aspirin | ☐ Advil | ☐ Toradol | ☐ Tylenol |
| ☐ Excedrin | ☐ Aleve | ☐ Cortisol | ☐ Prednisone |
| ☐ Dexamethasone | ☐ Other: _____ | | |

b. Narcotics:

| | | | |
|---|---|---|---|
| ☐ Fiorinal | ☐ Vicodin | ☐ Percocet | ☐ Demerol |
| ☐ Oxycontin | ☐ Oxycodone | ☐ Hydrocodone | ☐ Fioricet |
| ☐ Other: _____ | | | |

c. Abortive:

| | | | |
|---|---|---|---|
| ☐ Cafegot | ☐ Relpax | ☐ Treximet | ☐ Maxalt |
| ☐ Amerge | ☐ Frova | ☐ Zomig | ☐ Midrin |
| ☐ Sumatriptan | ☐ Imitrex | ☐ Other: _____ | |

a. Preventative:

| | | | |
|---|---|---|---|
| ☐ Propranolol | ☐ Timolol | ☐ Nadolol | ☐ Metoprolol |
| ☐ Atenolol | ☐ Verapamil | ☐ Diltiazem | ☐ Amitriptyline |
| ☐ Nortriptyline | ☐ Topiramate | ☐ Elavil | ☐ Topamax |
| ☐ Clonidine | ☐ Feverfew | ☐ Dilantin | ☐ Depakote |
| ☐ Zoloft | ☐ Paxil | ☐ Prozac | ☐ Effexor |
| ☐ Wellbutrin | ☐ Trazodone | ☐ Protriptyline | ☐ Desipramine |
| ☐ Doxepin | ☐ Other: _____ | | |

b. Miscellaneous:

| | | | |
|---|---|---|---|
| ☐ Phrenilin | ☐ DHE | ☐ Baclofen | ☐ Gabapentin |
| ☐ Cymbalta | ☐ Other: _____ | | |

27. Please list any **over-the-counter (OTC)** medications related to migraine that you are currently taking:

_____

_____

_____

_____

28. Have you ever had **Botox** to treat your migraines? ☐ YES ☐ NO

a. Where? ☐ Back of head (occipital region) ☐ Front of head (forehead/brow) ☐ Both

b. Who performed your Botox injections? _____

c. Did your Botox injections help?

☐ no relief (0%)

☐ some relief ( <50%)

☐ significant relief (>50%, but not complete)

☐ complete relief (100%)

29. Have you ever had **nerve blocks** to treat your migraines? ☐ YES ☐ NO

a. Where? ☐ Back of head (occipital region) ☐ Front of head (forehead/brow) ☐ Both

b. Who performed your nerve blocks? _____

c. Did your nerve blocks help at the time of the injection (while there was numbness)?

☐ no relief (0%)

☐ some relief ( <50%)

☐ significant relief (>50%, but not complete)

☐ complete relief (100%)

30. Have you ever had a **nerve stimulator** to treat your migraines? ☐ YES ☐ NO

a. Where? ☐ Back of head (occipital region) ☐ Front of head (forehead/brow) ☐ Both
b. Who performed your nerve stimulator?
c. Which nerve stimulator was implanted?
d. Did your nerve stimulator help?
   ☐ no relief (0%)
   ☐ some relief ( <50%)
   ☐ significant relief (>50%, but not complete)
   ☐ complete relief (100%)
e. For how many months did the nerve stimulator help?

31. Have you ever had **radiofrequency nerve ablation** to treat your migraines? YES NO

a. Where? ☐ Back of head (occipital region) ☐ Front of head (forehead/brow) ☐ Both
b. Who performed your nerve ablation? _____
c. Did your nerve ablation help?
   ☐ no relief (0%)
   ☐ some relief ( <50%)
   ☐ significant relief (>50%, but not complete)
   ☐ complete relief (100%)
d. For how many months did the nerve ablation help?

32. Have you sought treatment in the emergency room or hospital for your migraine headaches?

☐No ☐Yes – If yes, how many times? _____

33. Please list any other treatment(s) you have received for your migraine headaches:

☐ acupunture
☐ massage
☐ craniosacral therapy
☐ other: _____

34. How much would you estimate your migraine headache medications, appointments, and treatments
35. cost you **per month**? _____

36. How many of these medical expenses would you estimate are covered by your health insurance

37. **per month**? _____

38. To what extent do your migraine headaches affect your overall quality of life? (check one)

- ☐ Completely (unable to do desired activities)
- ☐ Moderately
- ☐ Minimally
- ☐ Not at all (able to do desired activities)

39. Do you have/had any of the following **medical conditions**? (check all that apply)

| | | |
|---|---|---|
| ☐ Diabetes | ☐ Heart attack | ☐ Stroke |
| ☐ Epilepsy | ☐ Hypertension | ☐ Hypotension |
| ☐ Depression | ☐ Fibromyalgia | ☐ Thyroid disorder |
| ☐ Asthma | ☐ Lupus | ☐ Peripheral neuropathy |
| ☐ Carpal tunnel | ☐ Shingles | ☐ Cold sores/herpes |

☐ Other: _____

40. Please list any previous surgeries you have had and when they took place:

_____

_____

_____

_____

41. What is your approximate consumption of the following:

a. Coffee/Tea/Caffeinated Soda: _____ per day / week / month
b. Alcohol: _____ per day / week / month
c. Tobacco: _____ per day / week / month
d. Other intoxicating/mind altering drugs: _____ per day / week / month

42. Please list any **medication allergies** you have:

_____

_____

43. Do any of your family members have migraine headaches?

☐No ☐Yes – If yes, who? _____

44. Please list any additional information that you feel is important to your medical care/history:

_____

_____