Mid-Maryland Neurology

HEADACHE Follow-Up

Name: **Date:**

Patient Section:

Since the last visit your *headaches* are:	❑ Improved	❑ Worse	❑ Unchanged
Since the last visit your *mood* is:	❑ Improved	❑ Worse	❑ Unchanged
Since the last visit your *sleeping* is:	❑ Improved	❑ Worse	❑ Unchanged
How many *total days* the last 30 days with any headanche ? (*All headache days/types*)			
How many *total days* in the last 30 days with a severe headache? (All headache days)			
How many days in the past 30 days have you taken *pain medicine* ? (Include Tylenol, Excedrin etc.)			

MIDAS Questionnaire (Migraine Disability Assessment)

1. On how many days in the last 90 days did you *miss work or school* because of headaches?	
2. How many days in the last 90 days was your *productivity at work or school reduced by half* or more because of your headaches? (Don't include days counted in question 1)	
3. On how many days in the last 90 days did you *not do household work* because of headache?	
4. How many days in the last 90 days was your *productivity in household work reduced by half or more* due to headaches? (Don't include days counted in question 3)	
5. On how many days in the last 3 months did you *miss family, social or leisure activities* due to headache?	
Total	

Review of Systems: Check any positives

❑ Blurred Vision	❑ Anxiety	❑ Muscle pain	❑ Short of breath
❑ Chest Pain	❑ Diarrhea	❑ Nausea	❑ Rash
❑ Confusion/ memory loss	❑ Constipation	❑ Numbness/tingling	❑ weight gain >5lb
❑ Dizziness	❑ Insomnia	❑ Tremor	❑ weight loss >5lb

PRIME-MD PHQ-2

Over the past 2 weeks have you often been bothered by any of the following problems?	Yes	No
1. Feeling down, depressed or hopeless?	❑	❑
2. Little interest or pleasure in doing things?	❑	❑

Current Medication (please list all)

Medication	Dose	Effective? Side effects, comments

Physician Section:

Vitals:	BP:	Pulse:	Weight:

NOTES: