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 *days* out of the past month have you had headaches?	
How many *severe* headaches have you had in the past month?	
How many days in the past month have you had to miss work/school due to headache?	
How many days in the past month have you taken *pain medicine* for headache?	

(Including Tylenol, Excedrin etc.)

Headache Medications

List your current headache medications and your experience so far:

Medication	Dose	Effective?	Side effects
		❑ Yes ❑ No ❑ Don't know	
		❑ Yes ❑ No ❑ Don't know	
		❑ Yes ❑ No ❑ Don't know	
		❑ Yes ❑ No ❑ Don't know	
		❑ Yes ❑ No ❑ Don't know	

Other Medication

List your other medications: (skip if listed elsewhere)

Medication	Dose	Effective?	Side effects
		❑ Yes ❑ No ❑ Don't know	
		❑ Yes ❑ No ❑ Don't know	
		❑ Yes ❑ No ❑ Don't know	
		❑ Yes ❑ No ❑ Don't know	
		❑ Yes ❑ No ❑ Don't know	

Review of Systems: Check any positives

❑ Blurred Vision	❑ Anxiety	❑ Muscle pain	❑ Rash
❑ Chest Pain	❑ Depression	❑ Nausea	❑ Weakness
❑ Confusion	❑ Headache	❑ Numbness	❑ weight gain >5lb
❑ Dizziness	❑ Insomnia	❑ Tremor	❑ weight loss >5lb

Testing: Check the tests you have has since your last visit.

❑ Blood Work ❑ Carotid Study ❑ CT ❑ EEG ❑ MRI ❑ Other_____

Physician Section:

Vitals:	BP:	Pulse:	Temp:	Weight:

NOTES: