# NEW YORK HEADACHE CENTER

www.NYHeadache.com

## Medical History

Name……Date …/…../…….
Please list all doctors you have seen in the past two years for any reason:
……
……
……
……

Have you recently had any of the following? (place an "X" in the ☐ 's):

- ☐ Ringing in your ears
- ☐ Hearing problems
- ☐ Dizziness
- ☐ Headaches
- ☐ Dental problems
- ☐ Sinus problems
- ☐ Head injury
- ☐ Fainting
- ☐ Double or blurred vision
- ☐ Seizures
- ☐ Depression
- ☐ Insomnia
- ☐ Excessive sleepiness
- ☐ Anxiety/nervousness
- ☐ Fatigue/lack of energy
- ☐ Menstrual problems
- ☐ Sexual problems
- ☐ Palpitations
- ☐ Chest pain
- ☐ Decline in memory
- ☐ Shortness of breath
- ☐ Chronic Cough
- ☐ Hoarseness
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stomach pain
- ☐ Nausea or vomiting
- ☐ Trouble holding urine
- ☐ Fever or chills
- ☐ Neck pain
- ☐ Low back pain
- ☐ Other pains……
- ☐ Leg muscle cramps
- ☐ Weakness, if yes, where?
  ……
- ☐ Numbness/pins and needles, if yes, where?
  ……
- ☐ Weight loss……/gain……
- ☐ PMS
- ☐ Other.....

Prescription and non-prescription medication, and amounts you are taking now:
……
……
……
……

Past medications, their dose, duration of treatment and reason for stopping them:
……
……
……
……


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