NEW YORK HEADACHE CENTER

www.NYHeadache.com

Medical History 2

Please check the past treatments you have had:

- ☐ Tens
- ☐ Traction
- ☐ Bed rest
- ☐ Other:..
- ☐ Surgery
- ☐ Psychotherapy
- ☐ Special diets
- ☐ Acupuncture
- ☐ Biofeedback
- ☐ Chiropractic
- ☐ Hot or cold

Prior evaluations (please check):

- ☐ Neurological exam
- ☐ CAT scan
- ☐ EEG
- ☐ MRI scan
- ☐ Angiogram
- ☐ Eye exam
- ☐ Dental exam
- ☐ ENT exam
- ☐ X-ray of ……………………..
- ☐ Psychiatric/psychological
- ☐ EMG
- ☐ Spinal tap

Other…………………………………………………………………..

Please list all your present medical problems:

……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………

Please list all past medical problems, operations, hospital admissions:

……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………

Please list your allergies, if any:…………………………………………………………………….
……………………………………………………………………………………………………..

Is there a family history of (please check):

- ☐ Headaches
- ☐ Alcoholism
- ☐ Excessive bleeding
- ☐ High blood pressure
- ☐ Arthritis
- ☐ Obesity
- ☐ Heart disease
- ☐ Tuberculosis
- ☐ Mental illness
- ☐ Strokes
- ☐ Diabetes
- ☐ Other……………………………………
- ☐ Seizures
- ☐ Goiter
- ☐ Cancer

Amounts per day: Alcohol……......Beer……..Coffee ……….Tea ……….Tonic/soda ………..
If you smoke, how much? ……………………………..

Physical exercise/frequency/duration:

……………………………………………………………………………………………………
……………………………………………………………………………………………………

Present work status:…………………………………………………………………………….
If you have children, please list their ages:……………………………………………………..
Please list hobbies/recreational activities:……………………………………………………….
Other:…………………………………………………………………………………………….