Clinical Research Institute
Migraine Medical History Form

Please fill out this form as completely as possible and bring it to your first research study appointment.

Name: _____DOB: _____ Today's Date: _____

Headache History Questions

HOW MANY TYPES OF HEADACHES DO YOU HAVE:

□ Migraine	Frequency_____times/ month	□ Sinus	Frequency_____times/ month
□ Tension	Frequency_____times/ month	□ Cluster	Frequency_____times/ month

HOW DO YOU TELL THE DIFFERENCE BETWEEN YOUR DIFFERENT TYPES OF HEADACHES:

_____

_____

Migraine History

ONSET YEAR:_____AGE AT ONSET_____

PRIOR DIAGNOSIS OF MIGRAINE: □ Yes □ No

if yes, made by_____date of diagnosis_____

Do your migraine headache attacks last 4 to 72 hours??_____yes _____no

LOCATION OF HEADACHES: □ right sided □ left sided □ all over □ front □back of head
□ other_____

DESCRIBE YOUR UNTREATED MIGRAINE PAIN INTENSITY _____Mild _____ Moderate _____ Severe

Do you have an AURA before pain starts?? (flashing lights, holes in vision)_____yes _____no

ASSOCIATED SYMPTOMS: circle all that apply

Light sensitive	Vomiting	runny nose	dizziness	diarrhea
Sound sensitive	aggravated by physical activity	watery eyes	weakness	blurred vision
Nausea	pulsating pain	nasal congestion	numbness	paralysis

DO YOU HAVE A FAMILY HISTORY OF MIGRAINE?:_____

CARDIAC HISTORY:

chest pain	□ yes □ no	diabetes	□ yes □ no
tobacco use	□ yes □ no	hypertension	□ yes □ no
high cholesterol	□ yes □ no		

PREVIOUS MIGRAINE MEDCATIONS/TREATMENTS: check all that apply

□Imitrex □Axert □Relpax □Frova □Amerge □Maxalt □Zomig
□NSAIDS □Narcotics □Ergotamine □Tylenol □Other_____

PREVIOUS TESTS: □ CT scan Date_____ □ MRI Date_____

Social History:
Do you or did you smoke tobacco? □ No □ Yes – what type (circle) Cigarettes Pipe Cigars
Chew tobacco? □ No □ Yes
How many years did you or have you smoked?_____ If no longer smoking, date stopped_____
If cigarettes, how many packs per day do you or did you smoke? _____
How many alcoholic beverages do you have per week? _____Per day? _____

Drug Allergy: □ No □ Yes
Name of drug: _____ Circle reaction: Hives Rash Itching Asthma Shock Other_____
Name of drug: _____ Circle reaction: Hives Rash Itching Asthma Shock Other_____

(OVER)

Please tell us if you currently have or have had a past history of any of the following conditions.
If you answer yes, please circle condition and give dates that the condition started, stopped or if it is continuing.

Head/Ears/Eyes	Problems with your eyes, ears or throat?	□ No □Yes _____
Allergies:	Seasonal, year round?	□ No □Yes _____
Nose/Throat	Speech or hearing problems?	□ No □Yes _____
	Headaches (cluster, tension, migraines) or seizures?	□ No □Yes _____
	Sinus problems (loss of smell, polyps, infection)?	□ No □Yes _____
	Mouth/throat problems (infections, hoarseness)	□ No □Yes _____
	Problems with vision?	□ No □Yes _____
Emotional:	Do you feel nervous, angry, suicidal, depressed, lonely, sad or out of control?	□ No □Yes _____
	Do you have trouble sleeping?	□ No □Yes _____
Endocrine:	Diagnosed with diabetes? When/type _____	□ No □Yes _____
	Do you have thyroid disease?	□ No □Yes _____
	Cataracts?	□ No □Yes _____
Circulatory:	Heart problems (high blood pressure, palpitations, chest pain, irregular heart beat)?	□No □Yes _____
Respiratory:	Lung problems (asthma, bronchitis, pneumonia, TB, emphysema)?	□ No □Yes _____
Gastrointestinal:	Recent problems with eating, drinking?	□ No □Yes _____
	Problems with nausea, vomiting, abdominal pain, or bloody stools?	□No □ Yes _____
	Recent weight changes or change in appetite within the last 3 months?	□ No □Yes _____
	Ulcers, hernias, indigestion, cirrhosis, or hepatitis?	□ No □Yes _____
Genital/Urinary:	Burning, pain or frequency when urinating?	□ No □Yes _____
	Have you been treated for a sexually transmitted disease? If yes, what _____	□ No □Yes _____
	Have you had kidney stones, prostate infection (male), or urinary tract (bladder) infection?	□ No □Yes _____
Immune:	Cancer, blood diseases, deficiencies, anemia?	□ No □Yes _____
Mobility:	Muscular/joint (i.e. arthritis) bone/orthopedic problems or difficulty with coordination?	□ No □Yes _____
Skin:	Problems with your skin (rash, hives, changes in skin/hair, cold sores, eczema)?	□ No □Yes _____

Have you ever had surgery? _ No _ Yes –Describe date and type of surgery.

_____

_____

Have you ever been hospitalized except for a surgery? _ No _ Yes-Describe _____

_____

_____

MEDICATIONS –list all medications (including prescription and over-the-counter) used in the past 6 months.

MEDICATION	DOSE	START DATE
Example: Ibuprofen	Two 200 mg tablets	April 15, 2011

☐ I consent to having the health information which I have provided on this form being collected and stored solely to assess my qualification for possible participation in a clinical research study at Clinical Research Institute, Inc.

Signature: _____ Date: _____