AMENT HEADACHE CENTER

MEDICAL HISTORY FORM

Date:	Name:		DOB/Age:
Height/Weight:	BP/Pulse	Referring MD:	Right / Left Handed

MEDICATIONS: (Please list medications and dosages)

Rx	Dosage

BLOOD THINNERS: ☐Coumadin ☐Plavix ☐Aspirin ☐Other: _____

ALLERGIES (Please list any allergies to medications):

Rx	Reaction

PAST MEDICAL HISTORY: (please check ALL that apply)

☐AIDS/HIV	☐Alcohol problems	☐Asthma	☐Atrial fibrillation
☐Balance problems	☐Bleeding disorder	☐Blood clots	☐Cancer (type?) _____
☐Carpal Tunnel Syndrome	☐Chemical Dependency	☐Depression	☐Diabetes
☐Epilepsy/Seizures	☐Emphysema/COPD	☐Fibromyalgia	☐Hearing Loss
☐Heart Attack	☐Heart Disease	☐High Blood Pressure	☐High Cholesterol
☐Kidney disease	☐Liver disease	☐Low back pain	☐Neck pain
☐Neuropathy	☐Osteoporosis	☐Pneumonia	☐Rheumatoid Arthritis
☐Sciatica	☐Stroke/TIA	☐Thyroid Problems	☐Tremors
☐Ulcers	☐Vertigo	☐Other: _____	☐Other: _____

www.amentheadachecenter.com 255 Detroit Street, Suite 100N | Denver, CO 80206

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PAST SURGICAL HISTORY, MAJOR ILLNESSES, or HOSPITALIZATIONS (not listed above)

Year	Surgery, Major Illness, or Hospitalization

CONSTITUTIONAL SYMPTOMS (mark any symptoms that you have had recently, and aren't listed in your Past Medical History):

General
☐Fever
☐Fatigue
☐Loss of appetite
☐Significant weight loss

Dermatology
☐Itching
☐Redness
☐Rash
☐Lumps
☐Skin cancer

Endocrinology
☐Excessive sweating/thirst
☐Temperature intolerance
☐Lactation

Ophthalmology
☐Vision Loss
☐Blurring of vision
☐Double vision

Neurology
☐Memory problems
☐Tremors
☐Balance difficulty
☐Numbness
☐Weakness
☐Speech difficulties
☐Dizziness
☐Seizures

Hematology
☐History of transfusions
☐Easy bruising

Cardiology
☐Chest Pain
☐Palpitations
☐Irregular heart beat
☐Leg swelling

Gastroenterology
☐Abdominal pain
☐Heartburn
☐Nausea
☐Vomiting
☐Blood in stool

ENT/Respiratory
☐Ringing in ears
☐Shortness of breath
☐Sleep apnea
☐Cold & Cough
☐Change in voice
☐Difficulty swallowing

Musculoskeletal
☐Joint pain
☐Joint swelling
☐Joint stiffness
☐Muscle aches

Psychology
☐Anxiety
☐Depression
☐Sleep disturbance

Genitourinary
☐Difficulty urinating
☐Urinary urgency
☐Increased frequency
☐Incontinence

FAMILY MEDICAL HISTORY:

Please list any known medical problems (in addition to headaches) in the family:

Father ☐Alive ☐Deceased _____
Mother ☐Alive ☐Deceased _____
Siblings _____
Children _____
Other _____

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SOCIAL HISTORY:

Occupation (if retired, list previous occupation): _____

Hobbies/interests: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Children: ☐# of children _____ ☐Ages of children _____

Caffeine (coffee/tea/soda-pop/other):	☐Yes	☐No	# cups/day_____
Alcohol (beer/wine/liquor):	☐Yes	☐No	#/week _____
Marijuana:	☐Yes	☐No	
Tobacco (smoke/chew/other):	☐Yes	☐No	#/day _____
Recreational drugs (please be truthful):	☐Yes	☐No	☐Current ☐Previous

Sleep: do you…

☐Have trouble falling asleep/staying asleep/both ☐Fall asleep frequently during the day ☐Require naps

☐Snore ☐Have Insomnia ☐Have diagnosed Sleep Apnea

Exercise: How many days per week do you exercise? _____

Type(s): _____

_____

Emotional Health (check any that apply):

☐Anxiety	☐Diagnosed personality disorder	☐Suicide attempt
☐Depression	☐Spousal abuse: current / prior	☐Bipolar Disorder
☐Irritable	☐Significant family stressors/Unstable family situation	☐Psychiatric hospitalization

NOTES (Other things you wish us to know): _____

_____

_____

_____

_____

_____

_____

Thank you!

Occupational:
Have you filed a Work Injury report with your employer?
Y N

Date of Injury:_____

Lawsuit planned /under consideration? Y N