Main Line HealthCare
Physician Network

GENERAL HISTORY

Patient Name:_____ **Date of Birth:**_____ **Date:**_____

What is your reason for your visit with Dr. Schulman?

_____

_____

_____

Have you ever been hospitalized or had surgery for any reason? If so, please give dates and type of surgery.

_____

_____

_____

Have you ever experienced any of the following symptoms?

_____YES	_____NO	Dizziness or Vertigo
_____YES	_____NO	Lightheadedness
_____YES	_____NO	Ringing in your ears
_____YES	_____NO	Hearing Loss
_____YES	_____NO	Fainting
_____YES	_____NO	Loss of consciousness
_____YES	_____NO	Convulsion or Seizure
_____YES	_____NO	Stroke
_____YES	_____NO	Blurry or Double Vision
_____YES	_____NO	Difficulty with bowel and/or bladder
_____YES	_____NO	Weakness of an arm or leg
_____YES	_____NO	Numbness or tingling of hand or foot

Do you currently use alcohol? _____Yes _____ No
If yes: _____# of alcoholic beverages per: Day_____ Week_____ Month_____
Do you currently smoke cigarettes? _____Yes _____ No
Did you smoke in the Past? _____Yes _____ No When did you quit?_____
Do you drink coffee or other caffeinated beverages? _____Yes _____ No If yes, how much?_____
How many hours of sleep do you get per night?_____

Do you have trouble falling asleep?	_____YES _____ NO
Do you wake up during the night for no apparent reason?	_____YES _____ NO
Do you snore?	_____YES _____ NO
Do you go for short periods without breathing in your sleep?	_____YES _____ NO
Do you have nightmares?	_____YES _____ NO
Do you take daytime naps?	_____YES _____ NO
Are you on a special diet?	_____YES _____ NO
Any recent change of weight?	_____YES _____ NO

If so # of pounds lost or gained_____

Tell me your personality type:
Happy_____ Depressed_____ Anxious_____ Worried_____
List some fun activities you enjoy:_____
Do you exercise? _____YES _____ NO AMOUNT_____ TYPE_____
If not, why?_____

Patient Name:_____ **Date of Birth:**_____ **Date:**_____

Please list all your current medicines (including over-the-counter) along with dosages:

_____

_____

_____

For WOMEN, please list:

Present method of birth control (including condoms):_____

Have you had a: Tubal Ligation _____Yes _____No

Hysterectomy: _____Yes _____No

ALLERGIES: Medicines:_____

Foods: _____

Dye and/or Iodine: _____

Other:_____

CHECK if you have experienced any of the following medical problems:

___Ear, Nose and Throat	___Emphysema/Asthma	___Head Injury/Concussion
___Sinus Disease	___Diabetes	___GYN problems/irregular periods
___Dental problems	___Stomach ulcers	___Arthritis
___Glaucoma	___Reflux	___Chronic Neck Pain
___Thyroid	___Abdominal pain	___Low back pain
___Heart Disease	___Kidney/Prostrate Disease	___Skin problems/Rash
___Irregular Heartbeat	___Liver Disease/Hepatitis	___Psychological problems
___High Blood Pressure	___Cancer	___Anxiety/Worrying
___Circulatory Problems	___0ther, specify_____	

FAMILY HISTORY:

If family members are living, please give current health status and age. If deceased, please give age deceased and the cause of death.

Mother:_____ Father:_____

Siblings:_____

CHECK if there is a family history of:

___Hypertension ___Diabetes ___Cancer ___Stroke ___Headache ___Aneurysm ___Seizures

___Psychological Problems ___Cardiac Problems ___Alzheimer's

Patient Name:_____ **Date of Birth:**_____ **Date:**_____

DEVELOPMENTAL HISTORY:

Place of rearing: _____

Relationship with Mother:_____ Father:_____

Description of Childhood: _____

Were you ever abused ____ Yes ____ No ____ Physical ____ Emotional ____ Sexual

MARITAL HISTORY:

Single____ Married____ Divorce____ Separated____

Reason for divorce or separation_____

Present Marriage: Duration_____ Quality_____

Personality of Spouse _____

Relationship or sexual problems_____

CHILDREN: ____YES ____NO IF YES:

How Many_____ Ages and Sex_____

General History Reviewed by: (Signature)_____ Date:_____

Dr. Elliot A. Schulman

Main Line HealthCare
Physician Network

HEADACHE PROFILE

Patient Name:_____ **Date of Birth:**_____ **Date:**_____

1. Initial cause of your first headache:
   ☐ Injury ☐ flu like illness ☐ surgery ☐ unknown
2. At what age did your headaches begin: _____ Years old
3. Is the frequency of your headaches: ☐ increasing ☐ decreasing ☐ the same
   Is the duration of your headaches: ☐ increasing ☐ decreasing ☐ the same
   Is the intensity of your headaches: ☐ increasing ☐ decreasing ☐ the same
4. How often do your moderate or severe headaches occur:
   ☐ continuous ☐ daily ☐ _____times per week ☐ _____times per month
   My headache reaches its peak in: (Check all that apply)
   ☐ seconds (abrupt) ☐ minutes (gradual)
   My headache lasts:
   _____minutes _____hours _____all day _____days (number of days)
   How many headache free days are you having per month: _____days
   My headache occurs more frequently:
   ☐ at work ☐ particular season of the year (which one)_____
   ☐ on weekends
   ☐ on vacation ☐ other_____
5. Put an X on the line that corresponds to your headache severity: (use an X)
   0 5 10
   _____
   None most intense
   If you have more than one type of headache denote severity with an"0"
6. Are your headaches so severe that:
   ☐ you are confined to bed ☐ you can function, but not optimally ☐ my headaches do not impair my function
7. Have you lost time from work or school: ☐ Yes (if yes, how many days per month_____) ☐ No
8. Do your headaches curtail your social activities ☐ Yes ☐ No
9. In the past six months how many headaches have required an emergency room visit? _____
10. Describe your headache pain: (Choose one or two that are most appropriate)
    ☐ sharp ☐ dull ☐ burning ☐ stabbing ☐ achy ☐ pressing/squeezing ☐ throbbing/pulsing
11. My headaches are most often present:
    ☐ on awakening ☐ as the day progresses ☐ evenings
    ☐ varies ☐ they awaken me during the night
12. The pain is located:
    ☐ all over my head ☐ back of my head ☐ forehead ☐ on either side
    ☐ always on one side ☐ right ☐ left ☐ other_____
13. (For Women) are your headaches affected by:
    ☐ birth control pills ☐ menstrual periods ☐ pregnancy

Patient Name:_____ **Date of Birth:**_____ **Date:**_____

14. Headache can be precipitated by: (check all that apply)

☐ stress ☐ food ☐ worrying ☐ success ☐ fatigue ☐ alcohol ☐ hunger ☐ weather
☐ hot sun ☐ coughing ☐ chewing ☐ orgasm ☐ bending over ☐ physical exertion
☐ lack of sleep ☐ erect position ☐ over sleeping ☐ missing a meal ☐ vacation ☐ strong odors
☐ particular medications, please list which ones _____

15. Warning signals that occur prior to your headache (check all that apply)

☐ loss of vision ☐ numbness (where) _____
☐ loss of speech ☐ zig-zag lines ☐ dizziness ☐ weakness (where) _____
☐ other _____
length of warning _____
Do these warnings occur during the headache? ☐ Yes ☐ No Which Ones? _____

16. Associated Symptoms: (check all that apply)

☐ nausea and/or vomiting ☐ double vision ☐ diarrhea ☐ anxiety ☐ blindness
☐ difficulty concentrating ☐ ringing in ears ☐ fatigue ☐ irritability ☐ feeling washed out
☐ numbness ☐ pain with chewing ☐ difficulty talking ☐ light headedness
☐ tight/stiff neck ☐ loss of consciousness or blackouts ☐ weakness/numbness on one side of body
Intolerant to: ☐ lights ☐ sounds ☐ odors ☐ others _____

17. What do you do to make yourself more comfortable during a headache:

☐ lie still ☐ keep active ☐ pace ☐ turn off lights ☐ other _____

18. At the end of a headache are you: ☐ exhausted ☐ fatigued ☐ exhilarated ☐ Other _____
How long do you feel this way? _____

19. If you have had any of the following tests, give dates, location & results, if known:

MRI of head _____
MRA of head _____
CAT scan _____
EEG _____
Cervical spine MRI _____
Sinus x-rays _____
Angiogram _____
Spinal Tap _____

20. Who have you seen in the past regarding your headaches: (Give name and dates)

Neurological evaluation _____
Headache center _____
Internist/Family Practitioner _____
Ear, nose, & throat Practitioner _____
Dental Evaluation _____
Eye exam _____
Psychological/Psychiatric Therapy _____
Other _____

21. Check other treatments you have had: ☐ biofeedback/relaxation ☐ chiropractor ☐ physical therapy
☐ other _____

Headache Profile Reviewed: (Signature) _____ Date: _____

Patient Name:_____ **Date of Birth:**_____ **Date:**_____

MEDICATIONS:

PLEASE UNDERLINE EACH MEDICATION YOU HAVE USED IN THE PAST.
PLEASE CIRCLE EACH MEDICATION YOU ARE NOW USING.

ANALGESICS
Actiq/fentanyl
Anacin/Aspirin/Bufferin
Axsain cream/capsasin
BC or Goody's
Codeine/Tylenol #3 or #4
Darvon/Darvocet/propoxyphene
Demerol/methadone
Dilaudid/hydromorphone
Duragesic/fentanyl
Equagesic
Esgic/Phrenalin
Excedrin
Fioricet/Fiorinal/butalbital
Kadian/morphine
Lidocaine nasal spray
Lidoderm patch/lidocaine
Lorcet/Lortab/hydrocodone
MS Contin/MSIR
Nubain/nalbuphine
QxyContin/OxyIR
Percocet/Percodan/Tylox
Tylenol/acetaminophen
Sedapap
Stadol/butorphenol
Talwin/pentazocine
Ultram/Ultracet/tramadol
Vicodin/Vicoprofen

ANTI-MIGRAINE
Amerge
Axert
Belfergal
Cafergot/Wigraine
DHE-45 injection or IV
DHE nasal spray
DHE capsule
Droperidol
Ergomar/Ergotrate
Frova/frovatriptan
Imitrex injection
Imitrex nasal spray
Imitrex tablet
Lidocaine
Maxalt
Methergine
Midrin/Duradrin
Migranal/DHE nasal spray
Replax
Sansert
Zomig tablets/zolmitriptan
Zomig nasal spray

HEART/BLOQD PRESSURE MED
Atacand/candesartan
Blocadren/timolol
Calan/Verelan/verapamil
Capoten/catapril
Cardene/wilcardipine
Cardiem/diltiazem
Catapfes/clonidine
Coreg/Carvedilol
Corgard/nadolol
Inderal/propranolol
Lopressor/Toprol/metoprolol
Lotensin/benaxepril
Lotrel
Norvase/amlodipine
Procardia/nifedipine
Tenormin/atenolol

DECONGESTANT/ ANTIHISTAMINE
Allegra/fexofenadine
Antivert/meclizine
Beconase
Benadryl
Clarinex/Claritin
Dramamine/dimenhydrinate
Entex/guaifensin
Flonase
Naldecon
Nasonex
Periactin/cyrohepadine
Sudafed/pseudoephedrine
Zyrtec/cetirizine

ANTI-NAUSEANT
Compazine/prochlorperazine
Reglan/metoclopramide
Phenergan/promethazine
Tigan/trimethobenzamide
Vistaril/Atarax/hydroxyzine
Zofran/ondansetron

ANTI- INFLAMMATORIES
Advil/Motrin/ibuprofen
Aleve/Anaprox/naproxsen
Ansaid/flurbiprofen
Arthrotec
Bextra
Cataflam/Voltaren/dielofenac
Celebrex
Clinoril/sulindac
Daypro/oxaprozin
Feldene/piroxicam
Indocin/indomethacin
Lodine/ctodolac
Meclomen/meclofenamate
Mobic/meloxicam
Naprosyn/naproxen
Orudis/ketoprofen
Relafen/nabumetone
Toradol/Ketorolac
Vioxx

MUSCLE RELAXANTS
Liorisol/baclofen
Flexeril-Cyclobenzaprine
Norflex/orphenadrine
Norgesic
Parafon Forte/chlorzoxazone
Robaxin/methocarbamol
Skelaxin/metaxalone
Soma/carisoprodol
Zanaflex/tizanidine

ANTI-CONVULSANTS
Depakote/valproic/divalproex
Dilantin
Gabitril/tiagabine
Keppra/levetiracetam
Klonopin/clonazepam
Lamictal/lamotrigine
Neurontin/gabapentin
Phenobarbital
Pregabalin
Tegretol/Carbatrol/carbamazipine
Topamax/topiramate
Trileptal/oxycarbazepine
Zonegran/zonisarnide

STEROIDS
Decadron/dexamethazone
Hydrocortisone
Medrol/methylprednisone
Prednisone

SLEEPING PILLS/ TRANQUILIZERS
Abilify/aripipazole
Ambien/zolpidem
Ativan/lorazepam
BuSpar/buspirone
Dalmaneflurazepam
Halcion/triazolam
Librium/chlordiazepoxide
Melatonex/melatonin
Prosorn/estazolarn
Restoril/temazipam
Seconal/secobarbital
Seroquel/quetiapine
Sonata/zaleplon
Thorazine/chlorpromazine
Tranxene/clorazepate
Trilafon/perphenazine
Tylenol PM
Valium/diazepam
Xanax/alprazolam
Zyprexa/olanzapine

ANTI-DEPRESSANTS
Celexa/citalopram
Cymbalta/duloxetine
Desipramine/Norpramine
Desyrel/trazodone
Effexor/venlafaxine
Elavil/amitriptyline
Lexapro/escitalopram
Eskalith/lithium
Luvox/fluoxamine
Nardil/phenezine
Pamelor/nortriptyline
Paxil/Preva/paroxetine
Prozac/Sarafem/fluoxetine
Remeron/mirtazapine
Serzone/nefazodone
Sinequan/doxepin
Symbyax
Tofranil/Imipramine
Vivactil/protriptaline
Wellbutrin/buproprion
Zoloft/sertraline

HERBAL:
(Please list)

Other medications used for headache not listed above:

_____

_____

Drug Allergies:_____

Procedures for Headaches
Botox/botulinum toxin
Nerve blocks
Trigger point injections