Dartmouth-Hitchcock

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DEPARTMENT OF NEUROLOGY | Headache Center

Returning Patient Information Form

Before your follow-up appointment at the Headache Center, please print and complete this form ahead of time to bring with you to your appointment.

Your name:_____ Date:_____

Your primary care physician's name:_____

Do you have any new health issues since your last visit? Please describe:
_____

How many mild headache days do you have each month?_____

How many severe headache days do you have each month?_____

Do you have any new symptoms that come with your headache? Please list:
_____

Are you having trouble sleeping? If yes, how often?_____

Please describe your mood (ex: anxious, depressed, good):_____

How is your energy level (ex: good, variable, poor)?_____

Are you missing work because of your headaches? If yes, how often?_____

Please list amounts of:
Tobacco (cigarettes or other tobacco products used per day):_____
Alcohol (per week):_____
Caffeine (cups per day): _____
Exercise (hours per week/type):_____

List ALL of the medications you are taking now, including hormonal and over-the-counter medications:_____

_____

Are you having any issues or concerns with your current medications? Please describe:
_____

What is the most important issue you would like to discuss at your visit?
_____

Thank you for choosing the Headache Center for your care. We look forward to continuing to work with you to meet your goals!