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

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

II. 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: ______________
Dr. Elliot A. Schulman

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-MIGRAlNE
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