LEXINGTON Pediatric Practice
A Lexington Medical Center Physician Practice

811 West Main Street, Suite 204, Lexington, SC 29072
Phone: (803) 359-8855 • **Fax:** (803) 359-1257

3240 Sunset Boulevard, West Columbia, SC 29169
Phone: (803) 359-8855 • **Fax:** (803) 794-6480

LexPediatricPractice.com

Lexington Medical Center

Headache Information

Patient Name: _____ DOB: _____

Please tell us more about your child's headaches and complete the following paperwork prior to your visit.

PLEASE COMPLETE THE FOLLOWING:

1. I believe the primary cause of my child's headache is _____.
2. My child is here because of: ☐ School Concerns ☐ Headache Concerns ☐ Fainting ☐ Other Concerns (describe below)
   _____.
3. The headaches have been a problem for: ☐ Days ☐ Weeks ☐ Months ☐ Years
4. Did the headaches start with a specific illness or injury? ☐ Yes ☐ No
5. My child has more than one type of headache.
   If yes, please describe:_____ ☐ Yes ☐ No
6. Most of the headaches are similar. ☐ Yes ☐ No
7. My child complains of headaches: ☐ Daily ☐ _____Times per Week ☐ _____Times per Month
8. Is there a pattern to the headaches: similar days, hours, symptoms? ☐ Yes ☐ No
9. Does one part of the head hurt more? ☐ Front ☐ Right ☐ Left ☐ Back ☐ All Over
10. Do you have neck or back pain? ☐ Yes ☐ No
11. What symptoms are associated with the headache: (check yes or no below)

Light Sensitivity	☐ Yes	☐ No	Nausea	☐ Yes	☐ No	Sound Sensitivity	☐ Yes	☐ No
Dots or Lines in Vision	☐ Yes	☐ No	Vomiting	☐ Yes	☐ No	Numbness of Arms or Legs	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Tingling of Arms or Legs	☐ Yes	☐ No

   Other vision problems: _____
   Other symptoms: _____

12. Headaches are more common: ☐ Front ☐ Right ☐ Left ☐ Back ☐ All Over
13. Most of the pain lasts: ☐ Minutes ☐ Hours ☐ Most of the Day
14. Does the headache arouse the child from sleep? ☐ Never ☐ Rarely ☐ Often
15. Do the headaches interfere with your child's sleep? ☐ Yes ☐ No
16. Do they keep your child from falling asleep? ☐ Yes ☐ No
17. Do the headaches wake your child up in early morning? ☐ Always ☐ Occasionally ☐ Never
18. Have your child's headaches increased since they started in ☐ Frequency ☐ Severity ☐ Both
19. When did this worsen?_____ **OR** Have your child's headaches stayed about the same since they became a problem?_____
20. Is there anything that seems to trigger the headache? ☐ Food ☐ Smells ☐ Sound ☐ Worry

21. What makes the headache worse? (please check below)

☐ Bending Over	☐ Sports	☐ Noise
☐ Standing Up	☐ Coughing	☐ Fatigue
☐ Lights	☐ Hunger	☐ Stress
☐ Other: _____		

22. Does your child get motion sickness/car sickness?	☐ Yes	☐ No
23. FOR FEMALES: Are headaches associated with menstrual cycle? If yes, please describe:_____	☐ Yes	☐ No

24. How many days of school has the child missed due to headaches this school year?_____

25. When was the last day of school missed?_____

26. How many days a month do headaches cause your child to stop activity and lie down?_____

27. What other activities has your child missed due to headaches?_____

28. My child has had tests for headaches. (include dates and results of all tests)	☐ Yes	☐ No

☐ CT Scan _____	☐ Dental Testing _____
☐ MRI Scan _____	☐ Allergy Testing _____
☐ Eye Exam _____	☐ Other Testing _____

TREATMENT:

1. What makes the headache better? _____

2. Does the headache get better or go away with rest or sleep?	☐ Yes	☐ No

3. What medication treatment have you tried so far? (Include all over-the-counter, herbal and prescription medications, tablet size and dose tried for headache). _____

_____

_____

_____

_____

4. Medications that seem to help: _____

5. Is medication needed for nausea?	☐ Yes	☐ No

6. How often does your child use over the counter medications for headache?
☐ Daily ☐ _____ Times per Week ☐ _____ Times per Month Which type?_____

7. Have you tried? ☐ Ice ☐ Massage ☐ Heat ☐ Other: _____

SLEEP:

1. My child sleeps well most nights:	☐ Yes	☐ No

2. My child has trouble: ☐ Falling Asleep ☐ _____ Staying Asleep ☐ _____ Both

3. My child usually falls asleep at _____ (time) during the week and awakens at _____ (time).

4. Average hours of sleep per night during the week _____ on weekend _____.

5. Was sleep a problem before the headaches started?	☐ Yes	☐ No
6. Has sleep been a problem since the headaches started?	☐ Yes	☐ No
7. During sleep, does your child snore? If yes, is it: ☐ Loud and often ☐ Soft and occasional	☐ Yes	☐ No

8. During sleep does your child: ☐ Grind Teeth ☐ Walk ☐ Talk

9. Does your child sleep in parent's bed: ☐ Almost Every night ☐ Occasionally ☐ Never

HOME AND SCHOOL LIFE:

1. My child lives at home with (please check all that apply).

☐ Biological Mother	☐ Adoptive Parents
☐ Biological Father	☐ Siblings
☐ Grandmother	☐ Cousins
☐ Grandfather	☐ Other: _____

2. School is going well and without problems?	☐ Yes	☐ No
3. There is some stress in my child's life at: ☐ Home ☐ School ☐ Friends Please describe:_____		
4. Any previous stress that has improved?	☐ Yes	☐ No
5. Is there any history of behavior or emotional problems? If yes, please describe:_____	☐ Yes	☐ No
6. Does your child carry a heavy backpack for school?	☐ Yes	☐ No

7. My child spends _____ hours per day on the computer at home and _____ hours per day at school.
8. My child spends _____ hours per day using other electronics (TV, video games, cell phone).
9. My child spends _____ hours per day in some form of physical activity.
   The usual physical activity is:_____

NUTRITION:

1. Is your child overweight?	☐ Yes	☐ No
2. My child eats breakfast _____ days per week. Typical breakfast is:_____.		
3. My child eats well-balanced meals and snacks throughout the day?	☐ Yes	☐ No
4. My child skips meals often.	☐ Yes	☐ No

5. What does your child typically drink during the day?_____
6. My child drinks _____ glasses of water per day.
7. My child drinks _____ glasses of caffeinated beverages per day. Type _____

OTHER MEDICAL CONCERNS/PAST MEDICAL HISTORY:

1. The pregnancy with this child was uncomplicated with full-term delivery. If no, please describe:_____	☐ Yes	☐ No
2. My child has had normal language, gross motor and fine motor development. If no, please describe:_____	☐ Yes	☐ No

3. Has your child ever had: ☐ Seizures ☐ Meningitis ☐ Encephalitis ☐ Stroke ☐ Severe Head Injury
4. What other medical concerns/diagnosis does your child have? _____
   _____
5. Please list all other medications your child takes: _____
   _____
6. What other health care providers has your child seen in the last three years: _____
   _____
   _____
   _____
   _____

7. My child is allergic to the following medications:_____

8. Does the patient wear glasses or contacts? Last vision check:_____	☐ Yes	☐ No
9. Is there any history of behavior or emotional problems? If yes, please describe:_____	☐ Yes	☐ No

10. List surgeries or hospitalizations: _____

_____

FAMILY HISTORY:

1. Check all that apply:

☐ Migraine	☐ Depression
☐ Sinus Headaches	☐ Seizures
☐ Other Headaches	☐ Epilepsy
☐ Anxiety	☐ Stroke in Children

☐ Relatives with Migraine: _____

DETAILED DESCRIPTIONS OF MOST RECENT HEADACHES:

1. Describe in detail child's activities on the most recent day with headache (start from awakening to bedtime): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

2. Describe in detail child's activities on the most recent day of school missed due to headache (start from awakening to bedtime): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3. Medications used: Include name, dose, tablet strength and did it work?_____

_____

_____

_____