Romeo K. Fernandez, M.D., P.A.
Pediatric Neurology
7000 W Palmetto Park Road, Suite 307, Boca Raton, FL 33433 Telephone:(561) 288-5990 Fax: (954) 391-5008

Initial Headache Form

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

Appointment Date: _____ **Appointment Time:** _____

Pain Area & Intensity

Where does the headache pain start?

☐ temples ☐ back of head ☐ top of head

☐ forehead ☐ around eyes ☐ neck area

Does the pain move around? ☐ Yes ☐ No

If yes, please describe where: _____

_____

Describe the severity of the pain (*circle one*): 1 2 3 4 5 6 7 8 9 10

Describe the pain (*check all that apply*): ☐ throbbing/pulsating ☐ sharp ☐ pressure ☐ dull

☐ band-like, squeezing ☐ other: _____

Duration & Time-Frame

When do the headaches usually occur? (*check all that apply*): ☐ Early morning ☐ Mid-morning ☐ Afternoon

☐ Evenings ☐ At night/during sleep ☐ Other: _____

How long do they usually last? _____ minutes _____ hours _____ days

How often do they occur? _____ times/week _____ times/month _____ times/month ☐ daily/constantly

How long (days/months/years) have you been experiencing the headaches described above?

_____

Associated Symptoms

Please mark all that apply:

☐ vision problems	☐ nausea	☐ sensation problems	☐ irritability
☐ blurred vision	☐ vomiting	☐ difficulty talking	☐ runny nose
☐ loss of vision	☐ loss of appetite	☐ slurred speech	☐ loss of awareness
☐ loss of visual fields	☐ face looks pale or sweaty	☐ weakness	☐ anxiety
☐ tearing	☐ pain when chewing	☐ dizziness	☐ cold or sweaty
☐ eye redness	☐ neck stiffness or tenderness	☐ lightheadedness	☐ fatigue
☐ light sensitivity	☐ difficulty concentrating	☐ fever	☐ smell sensitivity
☐ noise sensitivity	☐ other: _____		

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Additional Information

Please mark all possible triggers for the headaches:

☐ physical activity	☐ depression	☐ not staying hydrated	☐ missing a meal
☐ sleeping too little	☐ straining	☐ menstrual cycles	☐ anxiety
☐ stress	☐ bending over	☐ other: _____	

Are the headaches getting worse? ☐ Yes ☐ No

What makes the headaches better? _____

_____

_____

Any family relatives with a history of headaches? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Any previous medical professional treatment for headaches? ☐ Yes ☐ No

If yes, please specify: _____

Have you ever had an MRI done? ☐ No ☐ Yes, on ____/____/____

Have you ever had a CT scan done? ☐ No ☐ Yes, on ____/____/____