Bond Eye Associates

Medical History Form

Full Name:_____ Date of Birth:_____

Current Medications
Please list all the medications that you are currently taking both for headaches and other reasons.

Medication:	Dose:	Frequency:	Duration:

Allergy:	Reaction:

Pharmacy
In order for prescriptions to be electronically sent, we require your pharmacy's **address, fax number & phone number.**

Pharmacy:_____ Address: _____
Phone Number: _____ Fax Number: _____

Type: ☐ Local ☐ Mail Order | Mail Order ID:_____

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Previous Medications

The following is a list of medications and treatment options sorted by generic name with the brand name in parentheses. Please **check all** medications and treatment options that you have tried for your headaches. Place an **asterisk (*)** on the right-hand side for any medications/treatments that were effective in helping reduce and/or eliminate your headache pain.

Alternative
Acupuncture
Biofeedback
Botulinum toxin type A (Botox)
Chiropractic
Facet Blocks
Nerve Blocks
Pain Pump
Trigger Point Injection
Physical Therapy
Meditation
Reiki

Analgesic
butalbital/aspirin/caffeine (Fiorinal)
butorphanol (Stadol)
diclofenac (Voltaren, Cataflam)
fentanyl (Duragesic, Actiq)
hydrocodone (Lorcet, Norco, Vicoden, Tylenol #3 or #4)
hydromorphone (Dilaudid)
indomethacin (Indocin)
ketorolac (Toradol)
mefenamic acid (Ponstel)
meloxicam (Mobic)
methadone (Dolophine)
morphine (Dadian, Ms Contin)
oxycodone (Oxycontin, Percocet)
propoxyphene (Darvocet)
tramadol (Ultram, Ultracet)

Anti-Anxiety
atarax (Hydroxyzine)
alprazolam (Xanax, Niravam)
buspirone (Buspar)
clonazepam (Klonopin)
clorazepate (Tranxene)
lorazepam (Ativan)
vistaril (Hydroxyzine)

Anti-Convulsant
carbamazepine (Tegretol)
divalproex sodium (Depakote)
gabapentin (Neurontin)
lamotrigine (Lamictal)
levetiracetam (Keppra)
magnesium oxcarbazepine (Trileptal)
pregabalin (Lyrica)
tiagabine (Gabatril)
topiramate (Topamax)
zonisamide (Zonegran)

Anti-Depressant
amitriptyline (Elavil)
amitriptyline+perphenazine (Triavil)
amitriptyline+chlordiazeloxide (Limbitrol)
aripiprazole (Abilify)
buproprion (Wellburtin)
citalopram (Celexa)
desipramine (Normpramin)
desvenlafaxine (Pristiq)
doxepin (Sinequan)
duloxetine (Cymbalta)
escitalopram (Lexapro)
fluoxetine (Prozac)
fluvoxamine (Luvox)
haloperidol (Haldol)
isocarboxazid (Marplan)
lithium (Eskalith, Lithobid)
milnacipran (Savelle)
mirtazapine (Remeron)
modafinil (Provigil)
nefazodone (Serzone)
nortiptyline (Pamelor, Aventyl)
olanzapine (Zyprexa, Zydis)
paroxetine (Paxil)
phenelzine (Nardil)
protriptyline (Vivactil)
quetiapine (Seroquel)
risperidone (Risperdal)
selegiline (Emsam, Zelapar)
sertraline (Zoloft)
venlafaxine (Effexor)
vilazodone (Viibryd)
ziprasidone (Geodon)

Anti-Migraine
almotriptan malate (Axert)
diclofenac (Cambia)
dihydroergotamine (DHE-45, migranal)
eletriptan (Relpax)
ergotamine (Rrgomar, Cafergot, Bellergal)
frovatriptan (Frova)
methylegonovine (Methergine)
naratriptan (Amerge)
rizatriptan (Maxalt)
sumatriptan (Alsuma, Imitrex, Sumavil, Trexime, Tosymra, Zembrace)
sumatriptan+naproxen sodium (Treximet)
ubrogepant (Ubrelvy)
zolmotripten (Zomig)

Blood Pressure
atenolol (Tenormin)
bisoprolol (Zebeta)
candesartan (Atacand)
clonidine (Catapres)
diltiazem (Cardizem, Cartia, Tiazac)
enalapril (Vasotec)
losartan (Cozaar)
metoprolol (Lopressor, Torprol xl)
nadolol (Corgard)
nebivolol (Bystolic)
nimodipine (Nimotop)
propranolol (Inderal)
verapamil (Verelan, Calan, Isoptin)

CGRP
eptinezumab-jjmr (Vyepti)
erenumab-aooe (Aimovig)
fremanezumab-vfrm (Ajovy)
galcanezumab-gnlm (Emgality)

Devices Cefaly
gammaCore
Nerivio TMS

Muscle Relaxer
baclofen (Lioresal)
carisoprodol (Soma)
chlorzoxazone (Parafon forte)
cyclobenzaprine (Flexeril)
metaxalone (Skelaxin)
orphenadrine (Norflex, Norgesic forte)
tizanidine (Zanaflex)

Sleep Aids melatonin
diazepam (Valium)
droperidol (Inapsine)
eszopiclone (Lunesta)
ramelteon (Rozerem)
trazadone (Desyrel)
zolpidem (Ambien)

Other oxygen
atomoxetine (Strattera)
cyproheptadine (Periactin)
dexamethasone (Decadron)
dextroamphetamine (Adderal)
diphendydramine (Benadryl)
memantine (Namenda)
methylprednisolone (Medrol)
prednisone

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Medical History Form

Please answer all questions to the best of your ability. Be assured, that your physician will review the information that you provide in the form during your visit.

Full Name:_____ Date of Birth:_____

Past Medical History

Please check all previous and current medical diagnoses from the list below. If known, please enter the month/year the diagnosis was made after each condition.

- ☐ Abnormal Heart Rhythm
- ☐ Allergy – Seasonal
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar
- ☐ Blood Clots
- ☐ Bowel Disease/Disorder
- ☐ Brain Tumor
- ☐ Cancer
- ☐ Cerebrovascular Disease/Stroke
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic Lung Disease
- ☐ Chronic Sinusitis
- ☐ COPD
- ☐ CRF (Chronic Renal Failure)
- ☐ CT of Head/Neck _____
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Emphysema
- ☐ Endocarditis
- ☐ Endocrinology Disorder
- ☐ Factor V Leiden Deficiency
- ☐ Fibromyalgia
- ☐ Giant Cell Arteritis
- ☐ GERD
- ☐ GI Bleed
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Human Immunodeficiency Virus
- ☐ Impotence
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ Lupus
- ☐ Liver Disease
- ☐ MI (Heart Attack)
- ☐ MRA Head _____
- ☐ MRI Head _____
- ☐ MRI Neck/Back _____
- ☐ Neurologic Disorder
- ☐ Osteoporosis
- ☐ Panic Disorder
- ☐ Patent Foramen Ovale
- ☐ Peptic Ulcer
- ☐ Prostate Disease
- ☐ Pulmonary Embolism
- ☐ Raynaud's Disease
- ☐ Seizure Disorder/Epilepsy
- ☐ Sleep Apnea
- ☐ Suicide Attempt
- ☐ Syncope
- ☐ Temporomandibular Joint Syndrome (TMJ)
- ☐ Thyroid Disorder
- ☐ Urinary Tract Infection
- ☐ Valvular Heart Disease

Past Surgical History

Please check all previous and current medical diagnoses from the list below. If known, please enter the month/year the diagnosis was made after each condition.

- ☐ Abdominal Surgery
- ☐ Adenoids
- ☐ Amputation
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Brain Surgery
- ☐ Breast Surgery
- ☐ C-Section
- ☐ CABG
- ☐ Carotid Endarterectomy
- ☐ Cataract Extraction
- ☐ Chiari Decompression
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ D & C
- ☐ Gallbladder Surgery
- ☐ Gastric Bypass
- ☐ Interventional pain procedures
- ☐ Joint replacement -_____
- ☐ Hysterectomy – partial/total
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Mitral Valve Replace
- ☐ Organ Transplant - _____
- ☐ Pacemaker
- ☐ Parathyroidectomy
- ☐ Pneumonectomy
- ☐ Prostatectomy
- ☐ PTCA
- ☐ Sleep Apnea Surgery
- ☐ Sinus Surgery
- ☐ Tonsillectomy
- ☐ TURP+
- ☐ Urinary Incontinence Surgery
- ☐ Vertebroplasty
- ☐ History of Anesthesia Problems
- ☐ History of Surgical Complications
- ☐ History of Post-operative Complications

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Medical History Form

Family History

Please check all the medical conditions that are related to your family history:

- ☐ Anesthetic Complications
- ☐ Anxiety
- ☐ Asthma
- ☐ Birth Defects
- ☐ Blood Clots
- ☐ Cancer - _____
- ☐ Chronic Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines Mother
- ☐ Migraines Father
- ☐ Migraines Brother
- ☐ Migraines Sister
- ☐ Migraines as a child
- ☐ Psychiatric Care
- ☐ Respiratory Disease
- ☐ Seizures/Epilepsy
- ☐ Severe Allergies
- ☐ Stroke
- ☐ Substance or Alcohol Abuse
- ☐ Suicide/Suicide Attempt
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Weight Disorder

Social History

Please check all the following that you have experienced in your life.

- ☐ Domestic Abuse
- ☐ Sexual Abuse
- ☐ Physical Abuse
- ☐ Verbal Abuse
- ☐ Substance Abuse
- ☐ Alcohol Abuse
- ☐ Abandoned/Orphaned as a child
- ☐ Suicidal Thoughts
- ☐ Suicidal Attempt
- ☐ Recent Loss of a Family Member or Friend
- ☐ Decreased Libido
- ☐ Considers Self Type A Personality
- ☐ Considers Self Type B Personality
- ☐ Recent Increase in Moodiness
- ☐ Recent Increase in Irritability
- ☐ Recent Increase in Anxiety
- ☐ Recent Increase in Depression

Stress

Areas of Stress include:

☐Work/School ☐Finances ☐Living Arrangements ☐Time Management ☐Legal Issues

☐Marriage/Significant Other ☐Parental Relationship ☐Sexuality ☐Relationship

☐Other: _____

How do you cope with stress?_____

_____

_____

Employment Status:

☐Full-time ☐Part-time ☐New Job ☐Recent Job Termination ☐Leave of Absence ☐Disability

Occupation:_____ Marital Status: ☐Married ☐Separated ☐Divorced ☐Widowed ☐Single

☐Currently Under Extreme Stress

Bond Eye Associates

Medical History Form

Review of Symptoms
Please place a check next to any true statements in relation to your health.

General
- ☐ Poor sleep quality
- ☐ Good sleep quality
- ☐ Varying sleep quality
- ☐ Taking sleep aids
- ☐ Sleeping < 6 hours/night
- ☐ Sleeping >10 hours/night
- ☐ Frequent nighttime waking
- ☐ Good appetite
- ☐ Poor appetite
- ☐ Intaking artificial sweetener
- ☐ Not intaking caffeine
- ☐ Caffeine intake < 100 mg/d
- ☐ Caffeine intake < 200 mg/d
- ☐ Caffeine intake > 300 mg/d
- ☐ Taking vitamins
- ☐ Taking minerals
- ☐ Taking herbal supplements

Allergy & Immune System
- ☐ Persistent infections
- ☐ Hives or rash
- ☐ Seasonal allergies

Cardiovascular
- ☐ Cold hands
- ☐ Cold feet
- ☐ Discoloration of hands
- ☐ Discoloration of feet
- ☐ Difficulty breathing at night
- ☐ Chest pain or discomfort
- ☐ Racing heart beats
- ☐ Skipping heart beats
- ☐ Fatigue
- ☐ Lightheadedness
- ☐ Episodes of near fainting
- ☐ Blacks-out, fainting
- ☐ Shortness of breath w/exertion
- ☐ Palpitations
- ☐ Swelling of hands or feet
- ☐ Difficulty breathing while lying down
- ☐ Leg cramps with exertion
- ☐ Bluish discoloration of lips or nails

Ears, Nose, Throat
- ☐ Decreased hearing
- ☐ Ringing in the ears
- ☐ Earache
- ☐ Sensitivity to Sound
- ☐ Nosebleeds
- ☐ Runny nose
- ☐ Stuffy nose
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Change in voice
- ☐ Sensitivity to smells

Eyes
- ☐ Vision loss – one eye
- ☐ Vision loss – both eyes
- ☐ Double vision
- ☐ Blurred vision
- ☐ Eye pain
- ☐ Pain with eye movement
- ☐ Eye redness
- ☐ Eyes tear excessively
- ☐ Halos
- ☐ Light sensitivity
- ☐ Worsening of vision

Gastrointestinal
- ☐ Stomach pain
- ☐ Excessive appetite
- ☐ Loss of appetite
- ☐ Indigestion
- ☐ Heartburn
- ☐ Regurgitation
- ☐ Vomiting
- ☐ Nausea
- ☐ Painful bowel movements
- ☐ Frequent gas
- ☐ Frequent constipation
- ☐ Frequent diarrhea
- ☐ Hemorrhoids
- ☐ Change in bowel habits stream

Hematology
- ☐ Enlarged lymph nodes
- ☐ Bleeding
- ☐ Skin discoloration
- ☐ Abnormal bruising
- ☐ Fevers

Genitourinary
- ☐ Burning with urination
- ☐ Urinary frequency
- ☐ Urinary hesitancy
- ☐ Nocturia
- ☐ Incontinence
- ☐ Inability to empty the bladder
- ☐ Trouble starting urination

Respiratory
- ☐ Sleep disturbances due to breathing
- ☐ Coughs frequently
- ☐ Shortness of breath
- ☐ Chest discomfort
- ☐ Wheezing
- ☐ Excessive sputum
- ☐ Excessive snoring
- ☐ Stops breathing during sleep
- ☐ Difficulty breathing

Neurological
- ☐ Difficulty with concentration
- ☐ Poor balance
- ☐ Numbness
- ☐ Inability to speak
- ☐ Falling down
- ☐ Tingling
- ☐ Brief paralysis
- ☐ Visual disturbances
- ☐ Seizures
- ☐ Weakness

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Medical History Form

Review of Symptoms Continued

Muscle/Skeletal System

- ☐ Bone pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Tender spots in muscles
- ☐ Back pain
- ☐ Muscle stiffness
- ☐ Muscle weakness
- ☐ Arthritis
- ☐ Gout
- ☐ Loss of strength
- ☐ Muscle aches

Psychological

- ☐ Sense of great danger
- ☐ Anxiety
- ☐ Thoughts of suicide
- ☐ Mental problems
- ☐ Depression
- ☐ Thoughts of violence
- ☐ Frightening vision or sounds
- ☐ Nightmares
- ☐ Night terrors
- ☐ Sleep walking

Endocrinology

- ☐ Excessive hunger
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Weight change
- ☐ Hair loss
- ☐ Lack of sexual drive
- ☐ Difficulty climaxing
- ☐ Regular menses
- ☐ Irregular menses
- ☐ Still menstruating
- ☐ Decreased length of menstrual flow
- ☐ Increased length of menstrual flow
- ☐ Excessively heavy periods
- ☐ Missed periods
- ☐ Pelvic pain
- ☐ Pain with intercourse
- ☐ Inability to conceive
- ☐ Multiple miscarriages
- ☐ Pain when ovulating
- ☐ Trying to conceive
- ☐ Currently pregnant
- ☐ Currently breastfeeding
- ☐ Last menstrual period _____

Contact Details:

On occasions, our physicians and clinical staff may need to contact you regarding your medical care. Please check below how you would prefer we communicate with you concerning your clinical information. We will use the phone numbers you provide on the Patient Registration Form.

- ☐ May leave a voicemail message on my home voicemail system.
- ☐ May leave a message with a family member at my home number.
- ☐ May leave a voicemail message on my cell phone voicemail system.
- ☐ May leave a voicemail message on my work voicemail system.
- ☐ May send text messages regarding my appointments and medical care.
- ☐ May send email messages regarding my appointments and medical care.

By signing this form, you agree with all information that you have selected and written on this form. Please note that YOU ARE RESPONSIBLE FOR NOTIFYING OUR OFFICE OF ANY CHANGES to any portion of this form.

Patient Name (Print):_____ Patient Signature: _____