NEW JERSEY HEADACHE INSTITUTE

History and Physical

Date:_____

First Name:_____ **Last Name**:_____

Chief Complaint (reason you are being seen today)

History of Present Illness (when did your problem being)

Medication(s) (Please list all medication you are currently taking)	
Name of Medication:	Dose/Directions:

Drug Allergies

Medical History (Please check all that apply)					
	Headache/Migraine		Myocardial Infarction		Genitourinary Disease
	Headache/Tension		Heart Murmur		Venereal Disease
	Epilepsy/Seizures		Hyper Tension		Arthritis
	Cerebral Vascular		COPD		Cancer
	Other Neuromuscular		Asthma		Tuberculosis
	Head Injury		Peptic Ulcer Disease		HIV
	Spinal Cord Injury		Bleeding Disorder		Alcohol Abuse
	Cervical Cord Injury		Anemia		Smoking
	Peripheral Nerve		Diabetes		Drug Abuse
	CNS Malignancy		Peripheral Vascular Disease		Exposures
	Depression		Thyroid Disease		Mumps
	Anxiety		Menstrual/Sexual Dysfunction		Measles
	Coronary Artery Disease		Other Endocrine		Allergies
	Arrhythmias		Liver Disease/Hepatitis		Rheumatic Fever
	Congestive Heart Failure		Renal Disease		Other

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