Patient Name ________________________________ DOB _____________

Dear New Patient, Date

Thank you for choosing us for your care needs. We look forward to seeing you at your upcoming appointment.

Your appointment with Kimberly Hurley, DNP, APRN, FNP-C is on

M/T/W/T/F ___________________ at ____________________ am/pm

Please check in 15 minutes before appointment for check in at ____________

To prepare for your upcoming appointment, please note the following:

Please return completed paperwork prior to your appointment

Please contact previous headache/neurology provider(s) and have records sent to the office

Please bring your photo identification and insurance cards

Cell phone use is not allowed during appointment with provider

Our office is located at:

1929 10th Ave E, Milan, IL, 61264

Our phone number is:

309-787-2600

We respectfully request you cancel appointment in advance if you cannot attend

Thank you,

Kimberly Hurley, DNP, APRN, FNP-C

Patient Name ___________________________________ DOB ______________

Preferred Name_________________________

Preferred Pronoun He/Him She/Her They/Them

Parent/Guardian Name (if under 18 years old) _____________________________

Preferred Pharmacy____________________ Prefered Lab ___________________

Past Medical History (please circle)

Asthma COPD Sleep Apnea Emphysema High Blood Pressure

High Cholesterol Heart Attack/MI Stroke/CVA Diabetes Kidney Stones

Kidney Disease/Kidney Failure Liver Disease Obesity/Overweight Constipation

Diarrhea Depression Anxiety PTSD Cancer Seizures Chronic Pain

Migraine/Headache Autoimmune Disease HIV/AIDS Head Injury/Trauma

Additional Medical History:

____

____

____

Past Surgical History:

____

____

Previous Hospitalizations (dates, reason and location):

____

____

____

Patient Name ___________________________________ DOB ______________

Allergies:

____

____

____

Social History:

Marital Status: Single Married Live-in partner Widowed Divorced

Children (genders and ages) ____

____

Occupation: __________________________________ Full time Part time

Hours Weekly_______

Cigarette Use: Yes No Packs per Day _________ Number of Years________

Alcoholic Beverage Use: Yes No Frequency _______ per _________

Recreational Substance Use: Yes No

Type/Frequency: ____

Meals Eaten Daily ________ Snacks Eaten Daily ________

Daily Water Intake ______oz Daily Soda intake _____oz Daily Coffee Intake ___

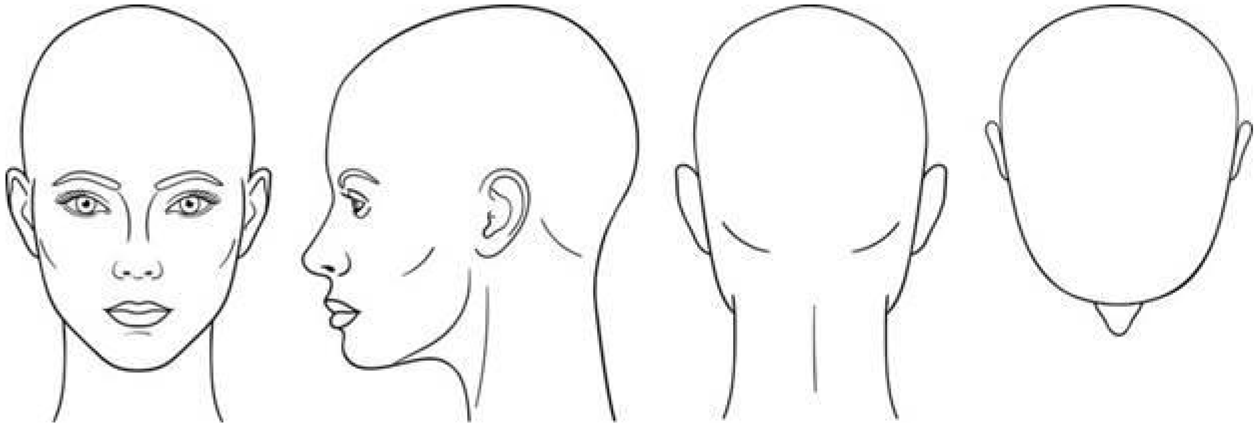
Patient Name ___________________________________ DOB ______________

Headache History:

Onset (First memory of having a headache that affected your ability to participate in events): _________

Timing: Same time every time Varies Specific months/seasons

Location: (shade areas of headache pain)



Duration: Shortest amount of time headaches last ____

Longest amount of time headaches last _____

Characteristics: Pressure Dull Aching Throbbing Stabbing Burning

Sharp Squeezing Crushing Pulsating Electric-like Other:

Aggravating Factors: (What makes your headaches worse) Lights Sounds

Smells Stress Activity Not eating/drinking Menstrual cycle

Weather changes Screen use Sleep issues Laying down Standing up

Relieving Factors: (Actions to help with pain): Lay down/Rest/Sleep Dark room

Quiet room Medications Meditation Mindfulness Deep breathing

Heat Ice/Cool compresses Essential oils Massage Shower/bath

Patient Name ___________________________________ DOB ______________

Aura: (Describe below any symptoms that tell you a headache is coming before pain starts)

Family members that get headaches:

Mother Father Sibling Children Other:

Severity: (How often do you have each type of headache)

Mild (Activities not affected) _________

Moderate (Activities somewhat affected) __________

Severe (Completely affects activities) _________

Associated Symptoms: (Circle problems that also occur with headaches)
sensitive to sound sparkly stars spots in vision wavy lines flashing lights blurred vision tunnel vision loss of vision sensitive to light tinnitus/ear ringing muffled hearing sensitive to sound dizziness loss of balance paresthesia/numbness and tingling difficulty thinking difficulty concentrating difficulty finding words difficulty speaking/slurred speech brain fog nausea vomiting

Are your current headaches (Circle statements that are true)

New Worsening Positional Maximum intensity within 1 minute

Pregnancy-related Worsened with cough/bowel movements

Occurring with a specific activity Occurring with vision loss

Occurring with pulsating ringing in ears (fluid rushing/heartbeat)

Started before age 5 Started after age 65

Started after a head/neck/back injury

Occurring with fever/chills/night sweats/muscle pain/weakness

Patient Name ___________________________________ DOB ______________

Migraine Disability Assessment Test (MIDAS)

_______How many days in the last 3 months did you miss work or school due to headaches?

_______How many days in the last 3 months was your productivity at work or school reduced by half or more due to headaches?

_______How many days in the last 3 months did you not do household work (housework, home maintenance, shopping, caring for others, etc) due to headaches?

_______How many days in the last 3 months was your productivity with household work reduced by half or more due to headaches?

_______How many days in the last 3 months did you miss or cancel family, social, religious or leisure activities due to headaches?

Headache Impact Test (HIT-6)

N- Never R- Rarely S- Sometimes O- Often A- Always

____When you have headaches, how often is the pain severe?

_____How often do headaches limit your ability to do usual daily activities including household duties, work, school or social activities

_____When you have a headache, how often do you wish you could lie down?

_____In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

_____In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

_____In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

Patient Name ____________________________________ DOB _______________

Previous Medications

If you have taken any of the medications listed below, please estimate dates and reason for stopping (SE: side effects) or (I: ineffective/did not work)

Medication	Date Started	Date Stopped	Reason Stopped
Topiramate/Topamax/Trokendi			
Amitriptyline			
Propranolol			
Divalproex sodium/Depakote			
Lamotrigine/Lamictal			
Gabapentin/Neurontin			
Pregabalin/Lyrica			
Carbamazepine/Tegretol			
Oxcarbazepine/Trileptal			
Lacosamide/Vimpat			
Levetiracetam/Keppra			
Valproic Acid			
Nortriptyline			
Sertraline			
Escitalopram/Lexapro			
Paroxetine/Paxil			
Fluoxetine/Prozac			
Citalopram/Celexa			
Duloxetine/Cymbalta			
Venlafaxine/Effexor			
Desvenlafaxine/Pristiq			
Bupropion/Wellbutrin			

Patient Name ___________________________________ DOB ______________

Medication	Date Started	Date Stopped	Reason Stopped
Buspirone/Buspar			
Metoprolol/Lopressor			
Verapamil			
Candesartan			
Aimovig injections			
Emgality injections			
Ajovy injections			
Botox injections for migraine			
Vyepti infusions			
Nurtec			
Qulipta			
Almotriptan/Axert			
Naratriptan/Amerge			
Rizatriptan/Maxalt			
Sumatriptan/Imitrex			
Zolmitriptan/Zomig			
Frovatriptan/Frova			
Eletriptan/Relpax			
Sumatriptan nasal spray/Tosymra			
Sumatriptan injections/Zembrace			
Trudhesa nasal spray/DHE			
Zavzpret nasal spray			

Patient Name ______________________________ DOB ____________

Please list providers you have seen previously for your headaches:

____

____

____

Have you had any of these **symptoms in the last 2 weeks**? (Circle those that apply)

Weakness
Fatigue
Decrease Appetite
Weight Changes
Fevers
Blurred Vision
Vision Loss
Double Vision
Watery Eyes
Runny Nose
Nasal Congestion
Ear Pain
Hearing Loss
Ears Ringing
Vertigo
Jaw Pain
Sore Throat
Tooth Pain
Cough
Wheezing
Chest Pain
Difficulty Breathing
Heart racing
Swelling

Nausea
Vomiting
Diarrhea
Blood in Stool
Abdominal Pain
Urinary Frequency
Urinary Urgency
Urinary Burning
Blood in Urine
Muscle Pain
Joint Stiffness
Joint Swelling
Back Pain
Neck Pain
Skin Rash
Heat Intolerance
Cold Intolerance
Bruise Easily
Bleed Easily
Dizziness
Seizures
Numbness/Tingling
Tremor
Memory Loss
Anxiety
Depression