# Columbia University Headache Center

## FOLLOW-UP PATIENT INFORMATION SHEET

(Required at every visit for insurance compliance)

**Patient Name:** **Date:**

**List ALL your current medications (Headache and non-headache, including over-the counter, vitamins, herbals, oral contraceptives, etc.):**

**List any changes in your medication since the last visit:**

**Since your last visit have you had any of the following problems :**

| Y | N | |
|---|---|---|
| | | Change in marital status/job/school |
| | | Emotional trauma |
| | | Change in smoking/drinking habits/diet |
| | | Hospitalization/Surgery |
| | | Fatigue |
| | | Weight loss |
| | | Rash |
| | | Allergic reaction |
| | | New illness diagnosed |
| | | Fever |
| | | High blood pressure |
| | | Palpitations |
| | | Shortness of breath lying down/walking |
| | | Chest pain |
| | | Leg pain on walking |
| | | Ankle swelling |
| | | Cough |
| | | Wheezing |
| | | Difficulty breathing |
| | | Bleeding |
| | | Clotting |
| | | Bruising |
| | | Anemia |
| | | Constipation |
| | | Diarrhea |
| | | Joint pain, swelling, redness |
| | | Painfully cold hands/feet |
| | | Muscle aching |
| | | Sexual dysfunction |
| | | Breast lumps |
| | | Pregnancy/Menopause |

| Y | N | |
|---|---|---|
| | | Irregular periods |
| | | Bladder problems |
| | | Depression |
| | | Anxiety /Panic attacks |
| | | Change in skin or hair |
| | | Excessive urination or thirst |
| | | Diabetes |
| | | Thyroid disorder |
| | | Trouble falling /staying asleep |
| | | Daytime sleepiness |
| | | Seizures/shaking |
| | | Headaches |
| | | Low back pain |
| | | Weakness |
| | | Numbness |
| | | Speech problems |
| | | Change in hearing or vision |
| | | Loss of consciousness |
| | | Dizziness |
| | | Other problems |
| | | All other systems negative |

**Reviewed with patient on:**

**MD/NP signature:**