Name: _____

Date of Birth: _____

Date: _____

FOLLOW-UP VISIT QUESTIONNIARE

Your Typical Headache

	Much Better	Better	Same	Worse	Comments
Since Initial Visit					
Since Last Visit					

Side Effects of current medications you wish to discuss? ____ YES ____ NO Tolerable Intolerable
If yes, explain: _____

_____

Any change in headache symptoms, location, or character: ___YES ____ NO
If yes, explain: _____

_____

Any change in health or new medical problems? ____ YES ____ NO
If yes, explain: _____

_____

Visits to Emergency Department or hospitalizations since last visit?

For headache: ____ YES ____ NO
If yes, explain: _____

_____

For another problem? ____ YES ____ NO
If yes, explain: _____

_____

Visit to any other provider for urgent headache treatment since your last visit? ____ Yes ____ NO
List three questions you would like for your physician to address today:

1. _____
2. _____
3. _____