Orange County Migraine & Headache Center
Patient History Form

Name_____ Today's Date_____
Reason(s) for today's Visit_____
_____
Primary Care Provider_____ Address_____
Phone number of PCP_____ _____

Medications(include name, dosage, how taken)
1.
2.
3.
4.
5.
6.
7.

Supplements/Herbal Products (include name, dosage, how taken)
1.
2.
3.

ALLERGIES (include description of allergic reaction)
1.
2.

Health Habits
1. Smoking YES◯NO◯ Amount/day:
2. Alcohol YES◯NO◯ Amount/day:
3. Caffeine YES◯NO◯ Amount/day:

Past Medical History
1. High Blood Pressure YES ◯ NO ◯
2. Diabetes YES ◯ NO ◯
3. Heart Condition YES ◯ NO ◯
4. Prior Stroke YES ◯ NO ◯

Other Significant Medical History/Health Conditions (include on separate page if needed)

I verify that the above information is true and accurate to the best of my knowledge.

_____ _____
Signature of patient or parent if minor Date