Working with our doctors as treatment partners!

Medications Workbook

www.MigraineDisease.com

Medications can be a vital part of feeling and living well.

Use this workbook to track what medications you've tried and how they did for you and what medications you're currently taking.

There are also sheets for basic personal information and a basic medical history.

Completed copies of these forms can be very helpful to you and your doctors.

Basic Personal Information

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Personal Contact Information

Name:

Birth Date:

Street Address:

City:

State, Zip Code:

Home Phone Number:

Office Phone Number:

Emergency Contact:

Name:

Relationship:

Phone Number:

Primary Care Physician:

Name:

Phone Number:

Other Physician:

Name:

Phone Number:

Specialty:

Pharmacy:

Name/Location:

Phone Number:

Allergic Reactions or Problems With…

(medications, dietary supplements, foods, tape..)

Surgeries, Medical Conditions:

Medical Insurance Information:

Name on Policy:

Insurance Company:

Plan/Group #:

ID #:

Phone Number:

Basic Medical History

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Personal Contact Information

Name:

Birth Date:

Street Address:

City:

State, Zip Code:

Home Phone Number:

Office Phone Number:

Emergency Contact:

Name:

Relationship:

Phone Number:

Primary Care Physician:

Name:

Phone Number:

Other Physician:

Name:

Phone Number:

Specialty:

Pharmacy:

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Phone Number:

Allergic Reactions or Problems With…

(medications, dietary supplemsents, foods, tape…)

Surgeries, Medical Conditons:

Medical Insurance Information:

Name on Policy:

Insurance Company:

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ID #:

Phone Number:

Medical History Checklist

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Name: _____

Date of Birth: _____

Today's Date: _____

Previous Illnesses: Have you ever had any of the following?

	Yes	No
Allergies		
Anemia		
Anxiety		
Arthritis		
Asthma		
Bleeding/clotting disorders		
Blood transfusion		
Bronchitis		
Cancer		
Depression		
Diabetes		
Emphysema		
Headaches		
Heart disease		
Hepatitis		
High blood pressure		
Infections		
Kidney disease		
Meningitis		
Menstrual problems		
Migraines		
Mononucleosis		
Pneumonia		
Rheumatic fever		
Scarlet fever		
Seizures		
Sinusitis		
Sleep problems		
Stroke		
Thyroid problems		
Tuberculosis		
Ulcer		
Vision/eye problems		

Do you have a family history of any of the following?

	Yes	No
Anemia		
Anxiety		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Depression		
Diabetes		
Emphysema		
Headaches		
Heart disease		
Hepatitis		
High blood pressure		
Kidney disease		
Migraines		
Seizures		
Stroke		
Thyroid problems		

Immunizations:

Flu shot		
Chicken pox		
HPV		
Measles		
Pneumonia		
Polio		
Tetanus		

Other: _____

Medications tried for headaches and / or Migraine ***Working with our doctors as treatment partners!***

Name of medication	Dosage	Year tried	Worked? Yes / No	Notes: Reason it was discontinued, etc.

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