

## Migraine and Chronic headache Status Report Worksheet

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Condition stable on current regimen and no changes in treatment recommended:      Y      N

Type of migraine or headache (check all that apply):

- Classic/Common Migraine
- Chronic Tension headache
- Cluster Headache
- Ocular Migraine
- Complicated Migraine
- Other: \_\_\_\_\_

Frequency more than one episode per month?    Y      N  
If yes, how often per month: \_\_\_\_\_

In the last year, has the patient:

Been hospitalized for migraine or chronic headaches?	Y	N
Had more than 2 outpatient clinic/urgent care visits for migraines or chronic headaches?	Y	N
If seen in the clinic/urgent care, did the symptoms fully resolve with the treatment?	Y	N

Experienced symptoms:

Have they been only mild and controlled with medications?      Y      N

Of the symptoms experienced, did they include:

Neurological or TIA-type symptoms?	Y	N
Vertigo?	Y	N
Syncope?	Y	N
Mental status changes?	Y	N
Other: _____		

Medications include:

None or

Preventive:

Daily calcium channel blockers or beta blockers only for prophylaxis?      Y      N

Side effects:      None      or      \_\_\_\_\_

Abortive:

OTC headache medications?	Y	N	<u>Airman please note:</u>
Triptans?	Y	N	(24 hour no fly)
Metoclopramide (Reglan)?	Y	N	(48 hour no fly)
Promethazine (Phenergan)?	Y	N	(96 hour no fly)
Injectable medications or narcotics?	Y	N	Not allowed

\_\_\_\_\_  
Treating Physician's Signature

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Date

*Expert FAA Medical Assistance!*

**Clinic Locations:**

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