Injection Treatment Appointment (Botox, Aimovig, other)

Patient name:____

Name of person with you today:______________________________________

Relationship with the person with you:__________________________________

Today’s date:____

Date (approximate is fine) of your last injection:____________________________

Name of your current Family Doctor:____________________________________

How successful do you feel these injections have been for you:

Very Successful	Moderately Successful	Partly Successful	Not Successful
☐	☐	☐	☐

1. Have your headaches decreased to more or less than 50% as compared to previous?
Yes ☐ No ☐ ____

2. Did you have any problems with the last injection? Yes ☐ No ☐ ________________

3. How often are you having headaches and how often do you need a rescue medication like a triptan or narcotic for your headaches? __________________________
____
____

4. What other medications such as preventative medications are you taking for your headaches?____
____
____

5. Do you need your jaw injected? Yes ☐ No ☐ ______________________________

6. Please note concerns that you wish to address with Dr. Makus at this appointment:
____
____
____
____
____
____

Please use the back of the form if necessary for any notes / questions / concerns.