CC: Headache

HISTORY OF PRESENT ILLNESS:
Pt is a [\_], who presents with headache. Headache started [4-72 hrs] ago.

[Impact on daily life
-Pain is unilateral vs bilateral.
-Pt reports that the pain is worse with physical activity.
-Patient has tried taking
-Historically these headaches last
-Nausea/vomiting/photophobia/phonophobia
-Aura: Neurological event that precedes the headache. Fully reversible dysphasic speech disturbance, sensory symptoms that are fully reversible, including positive features (e.g., pins and needles) and/or negative features (e.g., numbness), visual symptoms that are fully reversible, including positive features (e.g., flickering lights, spots, lines) and/or negative features (e.g., loss of vision). Each symptom lasts at least 5 minutes, but no longer than 60 minutes
-currently using birth control
-PMH/family history of migraines
-chronic NSIAD or caffeine use
-Any triggers noted
-Associated symptoms and abnormalities
-Any changes in lifestyle (sleep, exercise, stress, etc.)]

[Pt denies any red flag symptoms including: worse headache ever, neurologic signs or seizures, new onset HA over age 50, persistent headache after Valsalva maneuver or exertion, progressively increasing severity, disturbs sleep, symptoms of (fever, neck stiffness, HTN, myalgia, weight loss), sudden onset or "thunderclap" headache, recent trauma]

Review of Systems:
Constitutional: No fevers, chills
Eye: No blurry vision
Respiratory: No shortness of breath
Cardiovascular: No Chest pain, palpitations, syncope
Gastrointestinal: No nausea, vomiting
Neuro: No extremity weakness, no numbness or tingling, no problems with speech.
Genitourinary: No dysuria

Vitals: [Stable]

PHYSICAL EXAMINATION:
GENERAL: Appears well, NAD
EYES: Anicteric sclerae. no lid-lag or proptosis. EOMI
RESPIRATORY: Normal respiratory effort. CTAB. No wheezes
CARDIOVASCULAR: No peripheral edema. RRR, no m/r/g.
SKIN: Warm and dry. No rash, lesions or ulcers.
MUSCULOSKELETAL: Moving all extremities. Normal gait and station.
NEURO: AOx3. Moving all extremities. Face is symmetric.
PSYCH: Intact judgment and insight. A&O

Labs: [None]
Imaging: [Not indicated]

A/P:
1. Headache
Pt presents with a [episodic vs chronic] [moderate/severe] migraine [without] aura. However, we are also considering other possible diagnosis including: Cluster headache, encephalitis, medication induced headache, tension headache, and trigeminal neuralgia. Less likely include acute glaucoma, subdural hematoma, pseudotumor cerebri, carbon monoxide poisoning, carotid artery dissection, etc.
[-As pt is exhibiting evidence of red flag symptoms (abnormal neurologic exam, unusual, prolonged, or persistent, change in frequency/severity, first or worst migraine) we will move forward with MRI w/out contrast (unless history of cancer or positional headache-spinal leak) to rule out causes of secondary headache
-Consider CBC, CMP, TSH w/reflex T4, Vitamin B12 with methylmalonic acid, and Vitamin D
-As there is concern for overuse headache, we will use hydroxyzine and gabapentin for short course]
-We will move forward with [30mg] Ketoralac, 50mg Benadryl, 25mg promethazine IM
-Pt was advised to continue treatment with Ibuprofen/Tylenol or Excedrin as directed
-Pt was advised that magnesium oxide or citrate 400-500 mg/day can be used for prevention of acute migraine
-We will also prescribe [Rizatriptan 5-10mg] for continued moderate/severe migraine. [Pt has no history of coronary artery disease, peripheral vascular disease, or ischemic stroke.]
-Pt was advised to use the medication early in the attack with the onset of pain rather than onset of aura in case of migraine with aura and can be taken with other rescue medications listed above
-Pt was advised that even a 50% reduction of headache days constitutes success, the goal of treatment is to increase overall quality of life.
-Pt was advised to make lifestyle modifications including consistent, quality sleep and stress management. Could consider yoga or meditation
-Avoidance of triggers, and healthy coping mechanisms. If acute headache, home, rest in quiet, dark room with cold compresses on forehead.
-Failure to improve patient is instructed to follow in clinic, InstaCare, or nearest emergency room

[-Could consider methocarbamol, valproic acid, steroid taper (prednisone 60mg or dexamethasone)
-Naratriptan longer acting, but slower onset
-Lasmiditan similar to triptan but does not cause vasoconstriction, good choice for a patient unable to take triptans due to vascular disease. Pt may experience dizziness and sedation since this drug is more centrally-acting. Patients are advised not to drive for 8-hours after taking
-Ubrogepant (Ubrelvy): 50-100mg as a single dose, if symptoms persists or return, may repeat dose after >=2hrs. Max dose 200mg/day. Can be taken with NSAIDs and triptan.
-Rimegepant (Nurtec): 75mg single dose/day. Prevention: 75mg every other day]