

MEDICAL ALERT CARD

(Last updated ____/____/____) Use pencil to allow for updates.

The owner of this card

Name _____

is diagnosed as a **Cluster Headache (CH) sufferer**
as defined by the ICHD-II Code: 3.1

Description

Attacks of severe, strictly unilateral pain which is orbital, supraorbital, temporal or in any combination of these sites, lasting 15-180 minutes and occurring from once every other day to 8 times a day. The attacks are associated with one or more of the following, all of which are ipsilateral: conjunctival injection, lacrimation, nasal congestion, rhinorrhoea, forehead and facial sweating, miosis, ptosis, eyelid oedema. **Most patients are restless and agitated during an attack.**

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Personal Details

Blood Type: _____

Address: _____

Phone: _____ Sex: _____

Age: ____ DOB: ____/____/____ Weight _____

Emergency/Medical Contacts

Name: _____ Relation: _____

Ph# Home: _____ Wk: _____

Cell Ph#: _____

Address: _____

Name: _____ Relation: _____

Ph# Home: _____ Wk: _____

Cell Ph#: _____

Address: _____

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Doctor: _____ Ph#: _____

Specialty: _____

Doctor: _____ Ph#: _____

Specialty: _____

Doctor: _____ Ph#: _____

Specialty: _____

Medical Insurance (optional)

Ins. Co. _____

Policy # _____

Group # _____

Medicaid # _____

Medicaid # _____

Emergency Treatment:

Administer 100% Oxygen with
Non-Rebreather Mask at 7-15 LPM

CH does NOT respond to the usual migraine treatments

Approved by: _____ Date ____/____/____

Print Doctor's Name: _____

My Doctors have prescribed in the past _____
and it has been effective.

Cluster Headache Diagnosis Confirmed

By: _____

Address: _____

Organization: _____

Phone: _____

() Episodic () Chronic

Link to ICHD-II

http://216.25.100.131/upload/CT_Clas/ihc_II_main_no_print.pdf

Allergies

Medicine:

() Antibiotics: () Penicillin () Sulfa () Tetracycline

() Other _____

() Pain Meds/Anesthesia: () Codeine () Demerol

() Lidocaine () Morphine () Novocaine

() Nitro Glycerine

() Other _____

() Environmental _____

() Insect Stings _____

() Foods _____

() Latex () X-Ray Dyes

() No known allergies

Other Medical Conditions

CH Medications

Medication	Dosage	Frequency	Reason
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Medications

Medication	Dosage	Frequency	Reason
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

if needed continue on reverse side

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