

HEADACHE

Subjective Data:

Allergies: _____

Chief complaint: _____

Location of pain: (frontal/parietal/occipital/generalized) _____

History:

Migraines Hypertension Sinus problems Recent trauma

Type of pain:

Dull Achy Intermittent Constant Throbbing Pressure Sharp
 Pain Scale: (0-10) _____

Associated symptoms:

Nausea / Vomiting Drowsiness Confusion Seizures
 Visual changes Fever Photophobia Dizziness

Current Medication: _____

Objective Data: (clinically indicated VS)

BP _____ Pulse _____ Resp. _____ Temp. _____ Wt. _____

AAOX3 Lethargic PERRLA Facial symmetry
 Vomiting Confused Pupils unequal Facial asymmetry
 Drowsiness Normal gait Abnormal gait Muscle spasm
 Moves all extremities Weakness in one or more extremities (Describe) _____

NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY IF:

- First severe headache
- Treatment of recent head injury
- Significant elevation of BP, pulse, or temperature
- Constricted or unequal pupils
- Bleeding / blood in ear canal
- Unsteady gait / vertigo
- Stiff neck or change in mental status
- Aura, photophobia
- Offender report increase of headaches intensity / frequency
- Temp > 101

Medical Provider/RN Notified: Date: _____ **Time:** _____ **Orders Received for Treatment:** Yes No

Assessment:

Alteration in comfort related to headache

Plan:

Nursing Intervention Routine:

- Cool compresses or warm showers to head and/ or neck
- Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4days

OR

- Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days

OR

- Tylenol/ASA/Caffeine (i.e. Excedrin Migraine, Pain-Off) 2 tablets p.o. three times a day for 4 days

Progress Note: _____

Offender Education:

- Instructed on factors that trigger headaches, stress reduction techniques, follow-up sick call if no improvement.
Offender verbalizes understanding of instructions.

LPN Signature/credentials: _____ **Date:** _____ **Time:** _____

RN/Provider Signature/credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

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