



Headache Questionnaire

All Headache Patients

We would appreciate your cooperation in filling out this form. In our evaluation of headache, your history is typically our most valuable tool for diagnosis and subsequent treatment. If you have any questions regarding this form, please ask.

Identification

Name: _____ Age: _____ Sex: _____

How were you referred to the Headache Clinic? (name, address, fax and phone of referring physician, if known; if not referred by a physician, write "self").

Headache History

How old were you when you first began to have headaches bad enough to interfere with your normal daily activities? _____

Has there been any recent change in your headaches? Yes No

If you answered yes, when did this change occur? _____

If you answered yes, please specify what type of change: _____

How many days within the last 30 days were you headache-free or nearly so? _____

Are your headaches ever incapacitating (e.g., have to leave work or school or lie down undisturbed)?

Yes No

How many headache days have you had in the past 30 days? _____

How many of these days were headaches severe? _____

Do you have daily headaches? Yes No

If yes, roughly how long have you had a headache every day? _____

How long do your worst headache attacks last? (check box)

- | | | | | |
|-------------------------------------|----------------------------------|-----------------------------------|---------------------------------------|------------------------------------|
| <input type="checkbox"/> 0-1 hr | <input type="checkbox"/> >1-3 hr | <input type="checkbox"/> 4-12 hr | <input type="checkbox"/> > 12-24 hr | <input type="checkbox"/> >24-48 hr |
| <input type="checkbox"/> > 48-72 hr | <input type="checkbox"/> > 72 hr | <input type="checkbox"/> constant | <input type="checkbox"/> too variable | <input type="checkbox"/> unknown |



With your most severe headaches, does physical activity worsen the pain? Yes No

Is your headache pain ever throbbing? Yes No

Is your headache ever localized to one side of the head? Yes No

If yes, is your headache always on the same side? Yes No

If yes, which side? Right Left

Do your headaches often seem to begin in your neck or skull base? Yes No

Do you ever experience any of the following symptoms in association with your headache attacks (before, during, or after)? Please check the appropriate boxes:

- eye tearing
- nasal congestion/runny nose
- eyelid drooping
- white part of eye becoming red
- nausea
- vomiting
- visual changes (*visual distortion*, "*flash cubes*", "*zig-zags*", "*blind spots*", "*sparkles*", etc).

(please describe: _____)

numbness or tingling in the face, arm or leg (please describe: _____)

inability to tolerate bright light (photophobia)

sensitivity to sound (phonophobia)

sensitivity to smell

sensitivity to motion

Do you know of anything that triggers your headaches? Yes No

If yes, please list triggers: _____

Medical History

Please check the following items that pertain to you and your medical history:

hypertension (high blood pressure)

heart disease (please describe: _____)

diabetes

significant head injury (if yes, was it within the past 6 months? Yes No

(if no, please describe: _____)

kidney stones

sleep apnea

panic attacks

drug allergies: please list drug(s) and reaction(s): _____

treated for depression in the past with counseling, medication, or both



Please list any other significant medical conditions or psychiatric problems not listed on the previous page for which you are under the care of another physician.

If you are a female and potentially able to become pregnant, are you practicing birth control? Yes No

If yes, what method? _____

Have you had a brain scan in the past? Yes No unknown

If yes, what type? CT MRI both unknown

Where and when was the most recent scan performed? _____

Family History

Has anyone in your family had a significant problem with headaches or been diagnosed as having migraine or "sick" headaches? Yes No unknown

If yes, who? _____

Social History

What is your occupation? _____

Are you: married divorced widowed single?

Do you have children? Yes No

If yes, please list gender and ages: _____

Please check one:

- never smoked tobacco
 - current smoker (# of cigarettes per day _____, # of years _____)
 - former smoker (quit date: _____, # of years _____)
 - never consumed alcoholic beverages
 - currently consume alcoholic beverages (# of drinks per week _____)
 - past history of drinking heavily (quit date: _____, # of years _____)
 - never used recreational drugs (marijuana, cocaine, heroin, etc)
 - currently use recreational drugs (which drug(s)?: _____)
 - past history of using recreational drugs (quit date: _____, which drug(s): _____)
-



Review of Systems

Are you currently having difficulties with your sleeping (insomnia, early morning awaking, "always sleepy", etc)?

Yes No

If yes, please describe: _____

Do you snore? Yes No

Have you experienced any weight changes? Yes No

If yes, please list how many pounds you: gained _____ lost _____

Are you currently depressed? Yes No

If yes, is your depression mild moderate severe?

Are you chronically anxious? Yes No

Other

Please note below anything else you think is important for your doctor to know.



Headache Preventative Medications, Past and/or Present

Drug Name	Maximum dose achieved	How long taken?	Effective? Y / N	Side effects, if any.	Why stopped?
Topiramate/short-acting (Topamax)					
Topiramate/long-acting (Trokendi)					
Divalroex (Depakote)					
Amitriptyline (Elavil)					
Nortriptyline (Pamelor)					
Propranolol (Inderal)					
Zonisamide (Zonegran)					
Verapamil					
Occipital nerve blocks					
Botox injections					
Other: _____					
Other: _____					
Other: _____					



Medications for Treatment of Acute Headache, Past and/or Present

Drug Name	Maximum dose achieved	How long taken?	Effective? Y / N	Side effects, if any.	Why stopped?
Oral sumatriptan (Imitrex)					
Injectable sumatriptan (Imitrex)					
Intranasal sumatriptan (Imitrex)					
Rizatriptan (Maxalt)					
Oral zolmitriptan (Zomig)					
Intranasal zolmitriptan (Zomig)					
Eletriptan (Relpax)					
Almotriptan (Axert)					
Frovatriptan (Frova)					
Naratriptan (Amerge)					
Treximet					
DHE nasal spray					
Injectable DHE					
Indomethacin					
Naproxen sodium					
Oral steroid (eg, prednisone)					
Cambia					
Other: _____					
Other: _____					
Other: _____					