
MEDICAL FACULTY ASSOCIATES

THE GEORGE WASHINGTON UNIVERSITY

Headache Questionnaire

EPISODES

1. How old were you when you first had these headaches? Age: _____

2. Did you have these headaches in the past? Yes No

3. When was your last headache? _____

4. On average, how often do you have these headaches? →

(TIMES PER)	Day	Week	Month

5. What about when your headaches were at their worst?

6. On average, how long does your headache last? →

(TIMES PER)	Minutes	Hours	Days

7. What about when your headaches were at their worst?

8. Does your headache tend to come on as attacks (suddenly)?

No Sometimes Usually Always

9. How would you describe the quality of pain?

throbbing, pulsating, pounding stabbing pressing/tightening
 dull ache squeezing Other _____

10. Does the pain usually occur on one side of your head? Yes No

Which side? Right Left Both Don't Know

11. ON THE DIAGRAM BELOW, PLEASE **CIRCLE** THE LOCATION OF PAIN.

FRONT

BACK

LEFT SIDE

RIGHT SIDE

LABEL

12. Does the pain usually change with any of the following?

- Walking or walking upstairs No Change Worse Better Never Tried Don't Know
- Jumping or playing No Change Worse Better Never Tried Don't Know
- Coughing, sneezing No Change Worse Better Never Tried Don't Know
- Sleeping No Change Worse Better Never Tried Don't Know
- After sleep No Change Worse Better Never Tried Don't Know

13. How would you characterize the intensity of the pain you experience?

- Mild Moderate Severe Extreme

TRIGGERS

14. Have you noticed your Headaches occurring after ingesting any foods such as...

- Cheese Chocolate Nuts Other _____
 Alcohol (any type) _____

VISUAL CHANGES

15. Do you ever have any changes in your vision with your headaches? Yes No

16. Do you ever have these changes in your vision without headaches? Yes No

17. Do you experience:

- Flickering or flashing lights, Showers of light? Never Sometimes Often Not Sure
- Blurred vision? Never Sometimes Often Not Sure
- Spots before eyes? Never Sometimes Often Not Sure
- Zigzag lines, Geometric shapes, Stars? Never Sometimes Often Not Sure

18. How long do these changes in your vision usually last? _____

19. How much time generally elapse between the beginning of the earliest visual change and the onset of the headache?

<u>SECONDS</u>	<u>MINUTES</u>	<u>HOURS</u>	<u>DAYS</u>

NEUROLOGICAL CHANGES

20. Are your headaches accompanied by any problems?

- speech? Never Sometimes Often Not Sure
- thinking? Never Sometimes Often Not Sure
- difficult word finding? Never Sometimes Often Not Sure
- sensations (numbness, weakness, tingling)? Never Sometimes Often Not Sure

LABEL

21. How much time generally elapse between the beginning of the earliest (neurological change) and the onset of the headache?

<u>SECONDS</u>	<u>MINUTES</u>	<u>HOURS</u>	<u>DAYS</u>

22. Are you usually able to tell when a headache is about to occur? Yes No

23. How are you able to tell? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Changes in vision | <input type="checkbox"/> Changes in mood |
| <input type="checkbox"/> Changes in speech | <input type="checkbox"/> Changes in appetite |
| <input type="checkbox"/> Difficulty thinking, concentrating | <input type="checkbox"/> Feeling ill, nauseated |
| <input type="checkbox"/> Numbness, tingling, Weakness | <input type="checkbox"/> Sleep disturbances |
| <input type="checkbox"/> Changes in energy, malaise | <input type="checkbox"/> Other _____ |

24. Do you ever feel nauseated, sick to your stomach, or have diarrhea or other digestive problems with your headaches? Yes No

25. Does light usually bother you during a headache? Yes No

26. Does noise (i.e. radio, TV, voices, moving a chair across the floor) usually bother you during a headache? Yes No

27. Do particular odors (i.e. perfume, food, gasoline, smoke) bother you during a headache? Yes No

WOMEN ONLY:

28. Are these headaches ever associated with your menstrual cycle? Yes No

29. When do your headaches begin, with respect to your period? Yes No

FAMILY HISTORY

30. Does anyone in your family suffer from Headaches? Yes No
Who? _____

31. Please provide any family history pertaining to your headaches.

MEDICATION HISTORY

32. Do you currently take any prescribed medicines to treat your headache? Yes No

33. Do you currently take non-prescribed or over-the-counter medicines for headaches? Yes No

LABEL

