

## HEADACHE QUESTIONNAIRE

Date: \_\_\_\_\_

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.

### PATIENT PORTION

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Sex.: M F (circle one) Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Who is your primary physician? \_\_\_\_\_

Address (if known): \_\_\_\_\_

### Headache History

How old were you when you had your first significant headache? \_\_\_\_\_

Over the past 2 months, how many individual headache attacks have you averaged per month? \_\_\_\_\_

How long does a typical headache attack last? (Circle one)

- a) 0-1 hr      b) > 1-6 hr      c) > 6-12 hr      d) > 12-24 hr      e) > 24-48 hr      f) > 48 - 72 hr  
g) > 72 hr      h) constant      i) too variable      j) unknown

Has there been any recent change in the character or frequency of your headaches? No Yes

If yes, please specify what type of change: \_\_\_\_\_

Check any of the following factors which seem to trigger a headache attack in you:

- |                                                    |                                                   |
|----------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> alcohol (specify types: ) | <input type="checkbox"/> missing meals            |
| <input type="checkbox"/> menstruation              | <input type="checkbox"/> caffeine                 |
| <input type="checkbox"/> emotional stress          | <input type="checkbox"/> changes in weather       |
| <input type="checkbox"/> odors (please list: )     | <input type="checkbox"/> other (please specify: ) |
| <input type="checkbox"/> fatigue                   |                                                   |

Are your headaches ever incapacitating (e.g., have to leave work/school or lie down undisturbed)? No Yes

How many days per month are you incapacitated by headache? \_\_\_\_\_

Where on this line does your typical (average) headache fall?

|-----|  
Level 1 (minimal pain) Level 10(unbearable pain)

Overall, how disabled do you feel you have been by headaches over the past 2 months?

|-----|  
No problem with headaches Totally disabled by frequent/severe headache

Is your headache pain ever throbbing? No Yes Unknown  
(If yes, what percent of your headache attacks involve "throbbing" pain? \_\_\_% unknown

Is your headache ever localized to one side? \_\_\_\_% unknown

Does your headache typically occur at a certain time of day or on certain days of the week or month?  
 No Yes (If yes, please describe ) \_\_\_\_\_

Do you have any warning symptoms which alert you that you are going to have a headache attack?  
 No Yes (If yes, what type of warning do you have?) \_\_\_\_\_

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

- nasal congestion
- nausea (with what % of attacks do you experience nausea? \_\_\_\_% unknown)
- vomiting (with what % of attacks do you experience vomiting? \_\_\_\_% unknown)
- diarrhea
- visual changes (e.g.s, visual distortion, "flash cubes", "zig-zags", "blind spots", "sparkles"). (Please describe: ).
- inability to tolerate bright light (photophobia)
- inability to tolerate loud noise (phonophobia)
- numbness and/or tingling in face, arm, or leg (Please describe:). \_\_\_\_\_
- speech disturbance (Please describe: ). \_\_\_\_\_
- loss of balance
- vertigo (i.e., a spinning/"merry-go-around" sensation)
- extreme thirst, food cravings (Please describe: ).

What makes your headache worse? \_\_\_\_\_

What seems to help your headache? \_\_\_\_\_

**Medical and Social History**

Are you currently having difficulties with your sleeping (insomnia, early morning awakening, "always sleepy", etc.)? No Yes

Do you consider yourself to be currently under a significant amount of stress? No Yes

Do you adhere to a regular exercise program? No Yes

Do you eat at regular intervals? No Yes

Do you sleep at regular intervals? No Yes

Are you currently receiving formal treatment (counseling and/or medications) for anxiety or depression? No Yes

Please check the appropriate boxes:

- history of snoring
- history of lung disease
- anemia
- hypertension (high blood pressure)
- arthritis
- history of thyroid disease
- treated for depression in past

- recent weight loss
- past or present problems with significant motion sickness
- do you smoke cigarettes now? (Number of cigarettes per day )
- any significant head injury? ( if yes, within the past six months? No Yes )
- history of seizures
- any other significant medical or psychiatric problem or conditions for which you are under medical care? If yes, please explain: \_\_\_\_\_

What medications are you presently taking? (Please include over-the-counter medications, herbs, and birth control pills): \_\_\_\_\_

Have you taken oral contraceptives or estrogen replacement therapy in the past?    No    Yes  
 (If yes, effect on your headaches?    Better                  Worse    No change                  Can't recall  
 Have you been pregnant?    No    Yes  
 (If yes, effect on your headaches?    Better    Worse    No change                  Can't recall

Have you seen a doctor in the past for your headaches?                  No    Yes  
 His/Her diagnosis (if known): \_\_\_\_\_

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

What medications have you tried in the past for your headaches (e.g.s., Inderal, Cafergot, Elavil)?  
 \_\_\_\_\_

**Family History**

Has anyone in your family had a significant problem with headaches or been diagnosed as having migraine or "sick" headaches?    No    Yes (If yes, who? )                  unknown

**-STOP HERE-  
 Physician Only**

Diagnosis:

- Migraine without aura only
- Migraine with aura only
- Migraine both with and without aura
- Active chronic daily H/A (how long daily: months)
- Migraine with prolonged aura
- Acephalgic migraine
- Migrainous infarction
- Cluster
- Other
- Multiple (as checked above)