

Patient Questionnaire

Dear Patient,

In order to fully evaluate your headache condition, I would like you to fill out this headache survey before we meet in the office. Please bring this with you to your appointment.

Thank you.

1. Is there primarily one or more than one type of headache? _____

If you have more than one type, answer the following questions as they pertain to the most severe headache type.

2. When did the headaches begin? (age of onset) _____

3. What time of day does the headache occur most often? _____

Does it ever awaken you? _____

4. Where are the headaches located? (Check all that apply)

Neck Behind the eye Back of the head Temples Forehead Top of head
 Other _____

Are your headaches generally On one side? On both sides?

If one-sided, is it always on the same side? _____

If both-sided, does it usually start on one side? _____

5. How often do the attacks occur? Daily Weekly Monthly

If daily, how long have they occurred on a daily basis? _____

How many severe headaches per month? _____

Have they recently changed in frequency? _____

Have they recently changed in severity? _____

6. Are they better or worse on weekends or vacations? (Or during less stressful times?)

7. If untreated, how long do they last? Minutes Hours Days

On average, how long does it take for your headache to reach its peak intensity?

Minutes Hours Other _____

8. Please describe the pain. (Check all that apply)

Pulsating Throbbing Pounding Squeezing Vice-Like Tightening

Pressing Dull Constricting Stabbing Shock-Like Other _____

9. Please rate the severity of the headache where 0 is no pain and 10 is the worst pain that you have ever experienced. Usual headache _____ Worst headache _____

10. Do you feel any different one to two days before your headache occurs (e.g., euphoria, irritable, hyperactive, depressed, agitated, anxious)? _____

Do you crave certain foods before the headache comes on? _____

11. Do you have warning signs that the headache is soon to occur (an aura)? _____

Do you experience: (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> zigzag lines | <input type="checkbox"/> flashing or shimmering lights | <input type="checkbox"/> blurred vision |
| <input type="checkbox"/> blackened portions of visual field | <input type="checkbox"/> distorted shapes | <input type="checkbox"/> difficulty with speech |
| <input type="checkbox"/> one-sided visual loss | <input type="checkbox"/> one-sided numbness, tingling | <input type="checkbox"/> one-sided weakness |
| <input type="checkbox"/> disturbance in sense of smell | <input type="checkbox"/> excessive yawning | |

How long do these aura symptoms last? _____

How soon do the headaches come on after the aura? _____

12. During the headaches, are there any associated symptoms? (Check all that apply)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> room spinning | <input type="checkbox"/> sensitivity to bright lights | <input type="checkbox"/> sensitivity to sounds and/or odors | |
| <input type="checkbox"/> nausea | <input type="checkbox"/> vomiting | <input type="checkbox"/> tearing, droopy eyelids | <input type="checkbox"/> nasal congestion |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> unsteadiness | <input type="checkbox"/> numbness | <input type="checkbox"/> tingling |
| <input type="checkbox"/> difficulty with speech | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> difficulty hearing | <input type="checkbox"/> facial flushing |
| <input type="checkbox"/> one-sided runny nose or nasal congestion | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> other _____ | |

13. Are you a good sleeper? _____

Does your sleeping pattern change frequently? _____

When you have a severe headache, will sleep usually relieve the headache? _____

14. Does anything in particular bring on the headache? (Check all that apply)

- | | | | | | |
|---|---|--|--|--|---|
| <input type="checkbox"/> exercise | <input type="checkbox"/> sexual relations | <input type="checkbox"/> stress | <input type="checkbox"/> periods | <input type="checkbox"/> certain foods | <input type="checkbox"/> certain types of alcohol |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> lack of sleep | <input type="checkbox"/> caffeine | <input type="checkbox"/> bright lights | <input type="checkbox"/> high humidity | |
| <input type="checkbox"/> strobe/flickering lights | <input type="checkbox"/> fast action movies/video games | <input type="checkbox"/> weather changes | | | |
| <input type="checkbox"/> prolonged hunger | <input type="checkbox"/> other _____ | | | | |

Does walking up stairs or similar routine physical activity worsen the headache? _____

Do you avoid movement of even a mild nature (head movement or bending down) during an attack? _____

Are your headaches better or worse in a certain position? _____

15. Do you smoke cigarettes? _____

If so, how much and for how many years? _____

How much alcohol do you drink in a week s time? _____

How many cups of caffeinated coffee, tea or cola do you drink each day? _____

16. What is your occupation? _____

Have you ever had to take off work or alter your activities of daily living because of headaches? _____

How many days of work per month on average do you miss because of headaches? _____

How many days of work per month do you report to work with a headache but are significantly less effective than usual? _____

17. Are you frequently depressed? _____

Have you been depressed recently to the point where you have considered suicide? _____

What do you enjoy doing? _____

Have you ever been diagnosed with: (Check all that apply)

- manic depressive disorder anxiety panic attacks seizures
 Raynaud s phenomenon mitral valve prolapse

18. Do "sick" headaches or migraines run in your family (mom, sister, etc.)? _____

Do you remember anyone in your family having to come home from work or school regularly because of severe headaches? _____

19. Are your headaches seasonal? _____

Do you have hay fever or frequent sinus infections? _____

20. WOMEN: At what age did you first begin menstruating? _____

Are your headaches related to your periods or ovulation? _____

If so, when do they occur in relation to your period (before, during or after)? _____

Are your periods regular? _____

Have you ever been pregnant? _____

Did your headaches change during pregnancy? _____

Do you take birth control pills or other female hormones? _____

If so, which one(s) and for how long? _____

21. Do you take pain medications on a daily or near daily basis? _____

Which ones (including non-prescription)? _____

How many days of the week do you take something for your headache? _____

List all the over-the-counter pills you have taken in the past two weeks (pain pills, herbs, vitamins, etc.):

22. Have you ever been knocked out or suffered a serious head injury? _____

If yes, when? _____

Did you have significant motion sickness in childhood? _____

Have you ever had a spinal tap? _____

Have you ever had a whiplash, roller coaster or carnival ride-type injury? _____

23. Have you ever been treated for your headaches before? _____

By whom? _____ Have you ever seen a neurologist for your headaches? _____

Who did you see? _____ When? _____

24. What tests have been done to evaluate your headaches?

CT scan of the head

MRI of the head

Where? _____

Where? _____

When? _____

When? _____

What medications and/or treatments have you taken for your headache?

Please use the following abbreviations:

E = medication/treatment taken and effective

NE = medication/treatment taken and not effective

NT = medication/treatment taken and not tolerated

Preventive

- | | |
|--|--|
| <input type="checkbox"/> Inderal (propranolol) | <input type="checkbox"/> Calan/Isoptin/Verelan (verapamil) |
| <input type="checkbox"/> Corgard (nadolol) | <input type="checkbox"/> Depakote (valproic acid) |
| <input type="checkbox"/> Tenormin (atenolol) | <input type="checkbox"/> Topamax (topiramate) |
| <input type="checkbox"/> Elavil (amitriptyline) | <input type="checkbox"/> Neurontin (gabapentin) |
| <input type="checkbox"/> Pamelor (nortriptyline) | <input type="checkbox"/> Sansert (methysergide) |
| <input type="checkbox"/> Tofranil (imipramine) | <input type="checkbox"/> Other _____ |

Abortive

(please circle which meds were taken)

- | | |
|---|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Stadol nasal spray |
| <input type="checkbox"/> Tylenol (acetaminophen) | <input type="checkbox"/> Demerol/Tylenol with codeine/Vicodin/Percocet |
| <input type="checkbox"/> Excedrin/Anacin/Vanquish | <input type="checkbox"/> Imitrex pills/Zomig pills/Amerge pills/
Maxalt pills/Axert pills/Frova pills |
| <input type="checkbox"/> Ibuprofen/Motrin/Advil | <input type="checkbox"/> Imitrex injection/nasal spray |
| <input type="checkbox"/> Anaprox/Aleve/Naproxen | <input type="checkbox"/> Migranal (DHE) nasal spray |
| <input type="checkbox"/> Fiorinal/Fioricet/Esgic | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cafergot/Ergostat/Wigraine | _____ |
| <input type="checkbox"/> Midrin (isometheptene/dichloralphenazone/APAP) | _____ |

Other

- | | |
|---|---|
| <input type="checkbox"/> Acupuncture/Acupressure | <input type="checkbox"/> Prednisone |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Oxygen |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Riboflavin (B2)/Magnesium/Herbs (feverfew, etc.) |
| <input type="checkbox"/> Stress reduction / Yoga / Meditation | <input type="checkbox"/> Nerve blocks |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Ice/cold compresses |
| <input type="checkbox"/> Massage therapy | <input type="checkbox"/> Other _____ |

What are your goals for treatment? _____

Do you have any other questions regarding headaches? _____

Thank you for taking the time to complete this form.