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Name:

Headache Questionnaire

Date:

At what age did you have your first headache: ___________ What year did your current headaches begin: ___________

When was your last headache: ____

Are you ever free of pain completely? ❑ Yes ❑ No

Do you have more than one type of headaches? ❑ Yes ❑ No

If yes, describe them separately: ____

____

How many headaches (any type) do you have each month: ___________, how long do they last: ___________

How would you describe the pain of your most serious headaches (circle one or several):

throbbing pulsating dull aching pressure-like

sharp stabbing electric-like vise-like

Does the pain like: ❑ going from outside - in (compressing, stabbing) ❑ from inside - out (exploding, pushing out)

When you have a headache (and possibly after), does your scalp and face become sensitive to touch and do you avoid putting on glasses, jewelry or combing your hair? ❑ Yes ❑ No

Are your headaches brought on by:

your periods / hormonal changes exercise stress relaxation after stress change in weather

alcohol bright light / glare odors smoke noise lack of sleep too much sleep hunger

food additives certain foods

Do your headaches occur on any particular day of the week or time of day? ______________________________

____

Do you have any warning signs before the start of a headache? ❑ Yes ❑ No

Describe: ____

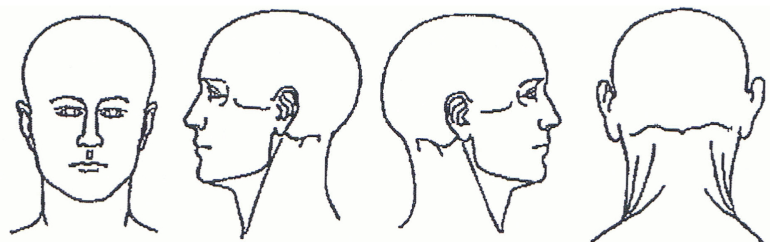
Circle any of the following symptoms you have with your headaches:

neck pain nausea vomiting light sensitivity dizziness noise sensitivity numbness

weakness fever confusion difficulty speaking tearing nasal congestion eyelid drooping

worsening of pain with movement other: ____

Please indicate with X's where you experience pain:



Headache Questionnaire

Have you ever been treated for headaches? ❑ Yes ❑ No

What kind of headaches were you told you have: ______________________________

Have you had any tests done to diagnose your headaches? ❑ Yes ❑ No

Describe: ______________________________

Which of the following medicines have you tried for your headaches (of any kind) (circle):

Advil / Ibuprofen	Decadron / Dexamethasone	Lamictal / Lamotrigine	Relpax / Eletriptan
Aimovig	Decongestants	Imitrex / Sumatriptan	Robaxin / Methocarbamol
Ajovy	Demerol	Inderal / Propranolol	Timolol
Aleve / Naproxen	Depakote / Divalproex	Indocin / Indomethacin	Toprol / Metoprolol
Amerge / Naratriptan	Desyrel / Tradozone	Lidocaine	Topamax / Topiramate
Anaprox / Naprosyn	DHE-45	Lithium	Tylenol
Aspirin	Dilantin / Phenytoin	Lyrica / Pregabalin	Ubrelvy
Atacand / Candesartan	Effexor / Venlafaxine	Maxalt / Rizatriptan	Ultram / Tramadol
Axert / Almotriptan	Elavil / Amitriptyline	Migralex	Valium / Diazepam
Benicar / Olmesartan	Emgality	Migranal	Vivactyl / Protriptyline
Botox	Esgic	Motrin / Ibuprofen	Vyepti
Bufferin	Excedrin	Neurontin / Gabapentin	Xanax / Alprazolam
Cafergot	Fioricet / Butalbital + APAP	Nurtec	Zanaflex / Tizanidine
Calan / Verapamil	Fiorinal / Butalbital + ASA	Pamelor / Notriptyline	Zomig / Zolmitriptan
Codeine	Flexeril / Cyclobenzaprine	Percocet / Oxycodone	Zonegran / Zonisamide
Cymbalta / Duloxetine	Frova / Frovatriptan	Qulipta	Other:

*Star those which helped, even for a while.

Have you tried any of the following alternative treatments (circle):

Biofeedback ***Acupuncture*** ***Chiropractic*** ***Physical Therapy*** ***Other: ___________________***

Supplements: (Feverfew, B2, Magnesium, MigreLief, CoQ10, Butterbur, Petadolex)

List all the headache medications and the amounts you are now taking (over the counter or prescribed):

- - -
- - -
- - -
- - -
- - -