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Headache Questionnaire

Name: _____ **Date:** _____

1. How long have you been experiencing headaches? _____
2. How many days of headaches do you have per month? _____
3. How many days per month do you have no headache at all? (Head pain free) _____
4. What are your headaches usually triggered by?:

   Bright light Strong odors Wine Chocolate Aged cheeses stress

   Lack of sleep skipping meals weather change menstrual cycle

   Other: _____

5. Are they associated with an Aura? An aura is often a perceptual disturbance experienced by some migraine sufferers before a migraine headache. (please circle) Yes No

   a. If yes to #3 please specify what type of Aura:

      Tunnel vision blurred vision Sensitivity to light Sensitivity to sound

      Fatigue Sensitivity to smell Flashes of light in vision

   Other: _____

6. Usual location of headache: (please check the appropriate box AND circle left or right)

   Front of head (Right or Left) Around eyes (Right or Left) Temple (Right or left)

   Side of head (Right or Left) Back of head (Right or Left) Top of neck

   Other: _____

7. Does the pain radiate (does the pain move from one place to another)? (please circle) Yes No

   Is yes, where: _____

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8. Describe the pain:

Pulsating/Throbbing Pressure Aching Sharp Burning Stabbing

Other: _____

9. Any associated symptoms?

Nausea Vomiting Scalp sensitivity Fever/ Chills Muscle aches

Weakness (If so where: _____) Congestion

10. Do your headaches interfere with your daily activities? YES NO

11. How severe are your headaches on a scale of 1-10? (With 10 being the worst pain) _____

12. How long do your headaches last? (in hours) _____

13. How many headaches do you have per week? _____

14. When do your headaches usually occur?

Wake you from sleep upon waking gradually develop during the day

Recur at the same time during the day

15. Do any of the following make your headache worse?

Rapid changes in position Coughing Sneezing Anger Exercise Laying down

Stooping/bending forward Excitement Being upright Straining/bearing down

16. What factors help to relieve your headache:

Darkness Sleep Vomiting Standing Medication

Other:_____

17. Any recent changes in your headache characteristics?

_____

_____

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18. Any recent changes in your headache frequency?

_____

_____

19. Any changes in your headache severity?

_____

_____

Please indicate which medications you have tried for migraine prevention:

Medication	**Approximate duration of use**	**Was it effective? Y/N**
Beta Blockers		
Atenolol (Tenorimin)		
Metoprolol		
Nadolol (Corgard)		
Bystolic (Nebivolol)		
Propranolol		
Bisoprolol (Zebeta)		
Calcium Channel Blockers		
Amlodipine (Norvasc)		
Nifedipine (Procardia)		
Diltiazem (Cardizem)		
Verapamil (Calan)		
ACE-Inhibitors		
Benazepril (lotensin)		
Enalapril (Vasotec)		
Lisinopril (Prinivil or Zestril)		
Quinapril (Accupril)		
Ramipril (Altace)		
Antiepiletics		
Topiramate (Topamax)		
Gabapentin (Neurontin)		

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Valproate (Depacan)		
Lamotrigrine (Lamictal)		
Depakote (Divalproex)		
Keppra (Levetiracetam)		
Dilantin (Phenytain)		
Other		
Gralise		
Lyrica		
Namenda		
Antidepressants		
Amitriptyline		
Doxepin		
Nortriptyline (Pamelor)		

Please indicate which medications you have tried to relieve an existing migraine:

Medication	Frequency of use in the last month	Was it effective? Y/N
Alsuma		
Amerge		
Axert		
Cambia		
Fioricet		
Frova		
Imitrex (Sumatriptan)		
Indomethacin		
Lortab (Hydrocodone)		

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Maxalt		
Midrin		
Medrol Dose Pak		
Migranal		
Naproxen		
Percocet (Oxycodone)		
Relpax		
Sprix		
Stadol		
Sumavel		
Toradol		
Treximet		
Zipsor		
Zomig		

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