New Patient Headache Questionnaire

Name: _____ Primary Care Provider_____

Please describe your headaches:

1. **When did your headaches start?** #____ days ago, # _____ weeks ago, # ____ months ago, # ____ years ago
2. **Did your headache start after a head injury?** ◯ No ◯ Yes → if yes, describe injury_____
3. **Did your headache start after an infection?** ◯ No ◯ Yes → if yes, what infection? _____
4. **Did your headache begin when you started or changed a medication?** ◯ No ◯ Yes → if yes, which medication? _____
5. **How many days** in a month do you **have a headache?** _____ How many **headache-free days** do you have in a month?_____
6. **How severe are your headaches?** (from 0 to 10=most severe pain possible): On average # ___ Most severe # ___
7. **Do you have more than one type of headache?** ◯ Yes ◯ No If yes, focus the following questions on your worst disability headache type.
8. **Where are your headaches located in general?** (check all that apply)

◯ Temple -- R L
◯ Back of head -- R L
◯ Top of head -- R L
◯ Other _____
◯ Front of head
◯ Around head
◯ Eye -- R L
◯ Ear-- R L
◯ Neck
◯ Jaw

9. **Your headaches usually feel like**: (check all that apply)

◯ Throbbing/Pulsing
◯ Achy
◯ Tight
◯ Dull
◯ Stabbing
◯ Pressure
◯ Shooting
◯ Burning
◯ Other _____

10. **How long do your headaches last in <u>HOURS</u>?** Shortest ___ Longest ___ Average ____ or are they constant? Yes No
11. **Your headaches are worse** in the ◯ morning ◯ afternoon ◯ evening ◯ during the night ◯ no pattern
12. **Are your headaches worse lying down or standing?** _____
13. **Do your headaches wake you up in the middle of the night?** ◯ Yes ◯ No; if yes, how often? _____
14. **Premonitory symptoms** (you experience one or more of these symptoms 1 to 2 days before onset of headache)

◯ Hyperactive
◯ Depressed feeling
◯ Irritability
◯ Feeling sluggish
◯ Difficulty concentrating
◯ Difficulty with speech
◯ Sensitive to light
◯ Sensitive to sound/noise
◯ Dizziness
◯ Excessive yawning
◯ Food cravings
◯ Increased appetite
◯ Decreased appetite
◯ Increased urination
◯ Stiff neck
◯ Other

15. **Do you have other symptoms during your headache?** (mark all that apply)

- ◯ Nausea or upset stomach/vomiting
- ◯ Sensitivity to light (prefer a dark room)
- ◯ Sensitivity to sound (prefer a quiet room)
- ◯ Sore/stiff neck
- ◯ Vision changes (blurred, spots, patterns)
- ◯ Eye tearing in only ONE EYE
- ◯ Runny nose in only ONE NOSTRIL
- ◯ Ringing in ears
- ◯ Eye-redness [Right Left Both]
- ◯ Drooping eyelid [R L Both]
- ◯ Swelling of eyelid [R L Both]
- ◯ Change in pupil [Larger Smaller]
- ◯ Dizziness/vertigo
- ◯ Imbalance
- ◯ Confusion
- ◯ Stroke like symptoms (facial droop, droopy eye lid, unable to move one arm or leg
- ◯ Sensitivity to smells
- ◯ Difficulty thinking/concentrating/focus
- ◯ Difficulty speaking/slurred speech
- ◯ Increased Urination
- ◯ Anxiety
- ◯ Irritability
- ◯ Memory problems
- ◯ Increased appetite
- ◯ Decreased appetite
- ◯ Diarrhea
- ◯ Constipation
- ◯ Insomnia
- ◯ Sleepiness
- ◯ Numbness/Tingling [R L Both] where?_____
- ◯ Other

16. **Aura**: (Do you have these symptoms before your headache begins?)

Visual

- ◯ Flashing lights
- ◯ Zigzag lines
- ◯ Wavy lines
- ◯ Loss of vision in one eye
- ◯ Loss of vision on one side
- ◯ Total blindness
- ◯ Tunnel vision
- ◯ Double vision
- ◯ Distorted vision
- ◯ Spots: bright/dark
- ◯ Geometric forms
- ◯ Other: _____

Sensory and other:

- ◯ Numbness/tingling [R L Both]
- ◯ Speech difficulty
- ◯ Vertigo
- ◯ Dizziness/unsteadiness
- ◯ Light headedness
- ◯ One-sided weakness [R L Both]
- ◯ Confusion/déjà vu/hallucinations
- ◯ Other: _____

If you have any of these symptoms above, they usually last: ____minutes and terminate ____minutes before pain starts OR occur ◯ during the head pain ◯ after the head pain ◯ without the head pain

17. **Provoking Factors** (Triggers = things that bring on a headache)

Food/beverage: ◯ Fasting/skipping meals ◯ Chocolate ◯ Caffeine ◯ Nitrates ◯ MSG ◯ Aged cheese

◯ Alcohol beverages: ◯ Wine: [Red White] ◯ Other:_____

Physical exertion: ◯ Coughing ◯ Talking ◯ Chewing ◯ Exercise ◯ Sexual intercourse

Hormonal: Menses ◯ Before ◯ During ◯ After; ◯ Pregnancy ◯ Menopause

Stress: ◯ Work ◯ Home ◯ Family ◯ Spouse ◯ Other: _____

Environmental: ◯ Allergies ◯ Weather changes ◯ Altitude ◯ Sunlight ◯ Other: _____

Sleep: ◯ Lack of sleep ◯ Too much sleep ◯ Change in wake/sleep

Other Triggers: _____

18. **Activity that worsens headache:**

◯ None ◯ Walking ◯ Climbing steps ◯ Exercise ◯ Other

19. **Relieving Factors:**

◯ Lying down ◯ Dark quiet room ◯ Hot compress ◯ Massage
◯ Standing ◯ Ice/Cold compress ◯ Keeping active/pacing ◯ Pregnancy
◯ Other:

20. Which **Acute medications** have you tried (medications taken to stop a headache)?

Acute (as needed) medication	On average, how many days per week?	Did it help? YES/NO	Currently taking? YES/NO
Acetaminophen (Tylenol)			
Aleve (Naprosyn, Naproxen)			
Almotriptan (Axert)			
Aspirin			
Baclofen (Lioresal)			
Celecoxib (Celebrex)			
Cyclobenazeprine (Flexeril)			
Diclofenac (Cambia)			
Dihydroergotamine (Migranal, DHE)			
Diphenhydramine (Benadryl)			
Eletriptan (Relpax)			
Excedrin			
Fioricet, Fiorinal			
Frovatriptan (Frova)			
Ibuprofen (Advil/Motrin)			
Indomethacin (Indocin)			
Ketorolac (Toradol)			
Lidocaine nasal spray			
Metaxalone (Skelaxin)			
Metoclopramide (Reglan)			
Midrin (Duradrin, Epidrin)			
Naratriptan (Amerge)			
Ondansetron (Zofran)			
Prochlorperazine (Compazine)			
Promethazine (Phenergan)			
Rizatriptan (Maxalt)			
Sumatriptan (Imitrex)			
Tizanidine (Zanaflex)			
Tramadol (Ultram)			
Vicodin, Codeine, Demerol, Percocet			
Zolmitriptan (Zomig)			
Other:			

21. **Preventive medications** (taken daily to prevent headaches)

Preventive (daily) medication	Approximate Dose/day	How long did you take it? Weeks/Months/Years	If stopped, why? No benefit/Side effects/Other
Amitriptyline (Elavil)			
Candesartan (Atacand)			
Gabapentin (Neurontin)			
Lamotrigine (Lamictal)			
Lisinopril (Zestril)			
Metoprolol (Lopressor)			
Methylergonovine (Methergine)			
Nortriptyline (Pamelor)			
Pregabalin (Lyrica)			
Propranolol (Inderal)			
Topiramate (Topamax)			
Valproic Acid (Depakote)			
Venlafaxine (Effexor)			
Verapamil (Calan SR)			
Zonisamide (Zonegran)			
Other:			

22. **Have you needed to go to the hospital or emergency room (ED) for headaches?** ◯ Yes ◯ No
If yes, how many times in the last 6 months? _____

23. **Have you been treated in the infusion clinic for your headaches?** ◯ Yes ◯ No
If yes, how many times in the last 6 months? _____

What did you receive in the ED or Infusion clinic?	Did it help? YES/NO	If headache returned, how long after treatment?
IV cocktail		
DHE (dihydroergotamine)		
Pain medication (narcotics)		
Steroid		
Other:		

24. **Behavioral and Alternative treatments used**

Supplements	Did it help?	How long did you take it? (Ws/Ms/Ys)	Behavioral/Physical therapy	Did it help?	How long did you take it? (Ws/Ms/Ys)
Multivitamin/multi mineral			Psychologist, therapist		
Riboflavin (vitamin B2)			Physical therapy		
Magnesium			Massage		
Co-enzyme Q10			Chiropractic therapy		
Melatonin			Acupressure/puncture		
Petasides (Butterbur)			Biofeedback		
Iron			Yoga		
Feverfew			Other:		

25. **Procedures used** (check all that apply):

Occipital nerve blocks: ◯ R ◯ L
Auriculotemporal nerve blocks: ◯ R ◯ L
Botox injections: # ____ Last _____ months ago
Supra-orbital/Supra-trochlear nerve block: ◯ R ◯ L
Head/Neck injections under X-ray guidance: ◯ Yes ◯ No
Other procedures _____

26. **Do you have any health issues involving?**

Other medical problems	Yes	No	If yes, describe		Yes	No	If yes, describe
Change in height or weight				Endocrine or reproductive			
Skin, including herpes, shingles				Blood or immune system			
Eyes (vision)				Muscles or bones			
Ears, nose, throat				Neurologic (seizures, other)			
Mouth (dental/orthodontic)				Depression			
Heart (palpitations, murmurs)				Anxiety			
Lungs (breathing issues/asthma)				ADHD			
Stomach (bowel movements)				Substance abuse			
Urination				Other:			

27. **Core Health Questions**

Exercise

How often do you exercise? _____ days per week
How long do you typically exercise? _____ minutes
What do you do for exercise? _____

Relaxation

How do you relax? _____
Do you wish you had more time to relax? ◯ Yes ◯ No
Have you had any training in relaxation techniques? ◯ Yes ◯ No

Sleep

On shorter nights, how long does it take you to fall asleep? _____ minutes
How many hours do you sleep a night? _____hours
Do you have any problems falling asleep? ◯ Yes ◯ No
Do you have any problems staying asleep? ◯ Yes ◯ No
Do you snore? ◯ Yes ◯ No Have you ever been told you have sleep apnea? ◯ Yes ◯ No
Do you grind your teeth? ◯ Yes ◯ No

Diet

How is your appetite? ◯ excellent ◯ good ◯ okay ◯ not good ◯ awful
Do you skip meals often? ◯ Yes ◯ No
How many 8oz glasses of water, juice, or milk do you drink per day? ____ glasses per day
Do you drink caffeinated beverages (soda, coffee, or tea)? ◯ Yes ◯ No; if yes how much ___ servings per week

28. **Testing**

Have you had brain and/or cervical spine MRI or CT? ◯ Yes ◯ No If yes, please make images/report available to your provider for appointment

Have you had lumbar puncture (spinal tap)? ◯ Yes ◯ No If yes, please make report available to your provider for appointment

MIDAS DISABILITY ASSESSMENT

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you.

INSTRUCTIONS: Please answer the following questions about all your headaches over the last **3 months**. Write your answer- **it must be <u>one number</u>, not a word or a range** - in the box next to each question. Write zero if you did not do the activity in the past **3 months**. If you don't keep a headache calendar, provide your best estimate.

	# of **DAYS**
1. On how many days in the last 3 months did you miss work or school because of your headaches? (If you did not attend work or school enter zero in the box.)	
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? *(Do not include days you counted in question 1 where you missed work or school. If you do not attend work or school enter zero in the box.)*	
3. On how many days in the last 3 months did you not do household work because of your headaches?	
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? *(Do not include days counted in question 3, where you did not do household work.)*	
5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches?	
Total (Questions 1-5)	
A. On how many days in the last 3 months did you have a headache? (If headache lasted more than one day, count each day.)	
B. On a scale of 0-10, on average, how painful were these headaches? (Where 0=no pain at all, and 10=pain which is as bad as it can be.)	

Office use only 0-5 Little to none, 6-10 mild, 11-20 moderate, 21-40 severe, 41+ very severe

ALLODYNIA QUESTIONNAIRE (ASC-12)					
How often do you experience increased pain or an unpleasant sensation on your skin during your most severe type of headache when you engage in each of the following?	**Does not apply to me**	**Never**	**Rarely**	**Less than half the time**	**Half of the time or more**
	Score: 0	Score: 0	Score: 0	Score: 1	Score: 2
Combing your hair					
Pulling your hair back (e.g., ponytail)					
Shaving your face					
Wearing eyeglasses					
Wearing contact lenses					
Wearing earrings					
Wearing a necklace					
Wearing tight clothing					
Taking a shower (when the water hits your face)					
Resting your face or head on a pillow					
Exposure to heat (e.g., cooking, washing your face with hot water)					
Exposure to cold (e.g., using an ice pack, washing your face with cold water)					
Total Score					
Sum of total scores					

Office use only: 0-2 none, 3-5 mild, 6-8 moderate, 9+ severe allodynia

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
	Score: 0	Score: 1	Score: 2	Score: 3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless than you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
Add Columns				
Sum of total scores				
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	☐ Not difficult at all	☐ Somewhat difficult	☐ Very difficult	☐ Extremely difficult

Office use only: 5 Mild, 10 moderate, 15 moderately severe, 20 severe

GENERAL ANXIETY DISORDER SCALE (GAD-7)				
Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
	Score: 0	Score: 1	Score: 2	Score: 3
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Becoming easily annoyed or irritable				
6. Feeling afraid as if something awful might happen				
Total Score				
Sum of total scores				

Office use only: 5 Mild, 10 moderate, 15 severe anxiety

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with people?

☐ Not difficult at all
☐ Somewhat difficult
☐ Very difficult
☐ Extremely difficult