Headache Questionnaire

When did your headaches start? _____.

How often do you have headaches? _____. How long have you been having them? # Weeks: _____ # Months: _____
For Women Only: Do the headaches coincide with your menstrual cycle? _____

When do your headaches occur? ☐AM ☐Midday ☐Evening ☐Night
How long does your average headache last? #Hours: ___ #Days: ___ Be Specific: _____

On a scale of 1-10 with 10 being the worst pain, how would you rate your average headache? _____
How long does it take before your headache pain is severe? #Minutes? _____. #Hours? _____.

What does the pain feel like? *(mark whichever applies)* ☐Throbbing ☐Stabbing ☐Pressure ☐Band-like ☐Other:_____.

Where is the pain?
Forehead and/or temples: ☐L Side ☐R Side ☐Both ☐Eye/Eyes:_____ ☐Back of head ☐Around the head
☐Other: _____.

Do you have any symptoms that alert you that a headache is coming?
Visual Changes: ☐Seeing Bright lights ☐Spots ☐Zig-Zag lines ☐Loss of vision ☐Blurred vision ☐Double vision
☐Yawning ☐Problems Speaking ☐Numbness or tingling ☐Irritability

How many times have you cancelled activities or missed work in the last month due headaches? _____. Have you ever been to the Emergency room because of headaches? _____.

When you have a headache do you have any of the following? **Please check each box that applies.**

☐Sensitivity to light	☐Loss of vision	☐Problems speaking
☐Sensitivity to noise	☐Double vision	☐Problems concentrating
☐Nausea	☐Tearing from one eye	☐Loss of coordination
☐Vomiting	☐Dizziness	☐Redness in one eye only
☐Drooping of one eyelid	☐Spinning or vertigo	☐Drainage from one nostril only

What relieves the symptoms? ☐Sleep ☐Dark Room ☐Ice ☐Medications ☐Other: _____

Do you know of anything that triggers your headaches?
☐Alcohol? ☐Lack of sleep? ☐Change of weather? ☐Stress? ☐Certain foods? List:_____

What Medications have you tried in the past? List what types, what dosage, and how long you have tried them:

_____

_____

_____

List Current Medications including Over-the-Counter medications such as Tylenol, Excedrin, Motrin, for example. Please list name, dosage, and how often you took them:

_____

_____

How much caffeine do you have every day? _____ How many soda's do you drink every day? _____ If so, do you drink diet or regular soda? _____.

Do you take any diet, nutritional or herbal supplements? _____

Any history of headaches in your ☐Family? ☐Parents? ☐Siblings?