Patient Name_____ Date_____

Headache History:

How long ago did the headaches start (What age)? _____

Location (Circle): Back of head / Neck / Front of head / Top of head / Sides of head
Both sides / Right only / Left only

Pain characteristic (Circle): throbbing / dull / pressure / sharp / burning / squeezing/ vice-like/other

Do you have the following symptoms with the Headache?

Nausea / Vomiting	Numbness / Tingling
Flashing lights, zig zags, spots	Difficulty talking
Blurry vision	Dizziness (spinning sensation)
Light sensitivity	Lightheadedness (feel like laying down)
Noise sensitivity	Hot, flush, watery eyes, runny nose
Worse pain with movement	Neck pain
Difficulty sleeping	Eyelid drooping

Severity at Worst 0/10: _____ Severity at least headache (0/10): _____
Do you live with a daily headache? Or episodic? Circle one

Do you feel you have more than one type of headache? Yes/N0

How often is the pain moderate to severe? _____ days per week

Length of Headache (Circle): seconds / 30 minutes / 1 hour / several hours / all day

Frequency of Headaches: Number of headache days _____ (per week / month)

Do you have any warning signs before a headache: Yes/no What are they?

_____

_____

_____

Most common time of day (Circle): Morning / Afternoon / Evening / Anytime

Number of days of school or work missed due to headache in the last 3 months:

_____ **Partial days**: _____

NEW PATIENT HEADACHE QUESTIONAIRE

Headache triggers (Circle): Changes in weather / Stress/ Lack of sleep/too much sleep/ hunger/ Caffeine Use / Chinese food (MSG) / Processed meats / Chocolate / Aged Meats /Aged Cheeses / Certain Smells / Menstrual Cycle / Exercise / Noise / Light/alcohol/smoke

What makes the headaches worse? _____

What makes it better? _____

How often do headaches wake you up from sleep? Never / _____ times per week

Current Medications for headaches (Circle):

Ibuprofen / Tylenol / Excedrin / Naproxen / Sumatriptan / Rizatriptan

Other: _____

How often do you take pain medication? _____ (Circle - per week / month)

Previous Medications / Treatment tried for headaches: on back page

Females: Have you started your period? Yes/No At what age? ____

Regular? _____ Headache worse with periods? _____

Lifestyle Habits:

Bed time: _____PM Wake time: _____AM

Sleep problems (Circle):

Falling asleep / staying asleep / snoring / daytime sleepiness

Do you use the computer or phone before bed? Yes/no

Do you have a normal sleep routine? Yes/no

Do you skip meals? Breakfast / Lunch / Dinner / Picky Eater / No

How many cups/bottles of water do you drink? _____ (per day)

Do you drink Caffeine – Coffee, Tea, Soda (Coke, Dr. Pepper, etc)?

No / Yes, how many? _____ (per week)

Screen time (Cell phone, TV, computer, video games, etc): _____ (hours per day)

Vision Checked recently? No / Yes; approximate date: _____

Exercise? Yes/No What do you do? _____

Any stressors at school /work/ family / personal? _____

Do you drink alcohol? Yes/no How much? _____/day/week

Do you smoke? Yes/no How much? _____

Are you Married or Single?

Do you have kids? Yes/no Ages? _____

Current Stress Level 0 = none and 10 = catastrophic _____

Who do you live with? _____

Are there any serious problems at home?

_____

_____

Do you have a family history of the following and who has it?

Migraine Headaches	Brain tumor
Other Headaches types	Seizures / Epilepsy
Brain aneurysm	Strokes before age 60 years
High blood pressure	Increased intracranial pressure
Diabetes	Mental Illness – depression/anxiety, etc
Sleep Disorders	Other:

Have you ever been to the ER for your headaches? Yes/no When?_____
Where? _____

Have you ever been admitted for headaches? _____
Have you ever had concussions? Been in car accidents? Yes/no
Have you ever had any Traumatic Brain Injuries?

Have you had any previous testing / evaluations? Please put dates if you know

CT Head	MRI Brain	Neurologist	Ophthalmologist	Other:

What meds are you taking for any other reason?

_____

_____

Have you tried any of these specific medications for headaches? (circle ones you have tried)

Tylenol Prednisone	Ibuprofen	Sumitriptan/Imitrex	Naproxen
Rizatriptan/Maxalt	Aspirin	Toradol	Naratriptan
Almotriptan	Relafen	Frovatriptan	Diclofenac
Reglan	Fioricet	Compazine	Midrin
Zofran/Ondansetron	DHE/Migranal	Phenergan	Eletriptan
Celebrex	Zolmitriptan	Benadryl	Excedrin
Dexamethasone	Diamox	Indomethacin	Robaxin
Tizanidine	Nurtec	Ubrelvy	

Have you ever been on any of these medications to PREVENT headaches?

Topamax	Zoloft	Depakote	Cymbalta
Keppra	Effexor	Neurontin	Periactin
Lyrica	Propranolol	Lamictal	Lisinopril
Zonegran	Doxycycline	Elavil/amitriptyline	Robaxin
Ajovy	Aimovig	Emgality	Nurtec
Qulipta			

Nerve Block or trigger point injections	Prozac	Botox

Have you tried any NON-MEDICATION treatments?

Massage	Acupuncture	Chiropractor
Physical Therapy	Biofeedback	Counseling

Supplements: Magnesium, B2, Migralief, Migravent, CoQ10, butterbur, feverfew

Do you have allergies? Yes/no**Do you have any other significant medical history?**

_____