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Headache Questionnaire

Name : _____

Date : _____

1. How long your headaches been present?

2. Description of Pain?

---- Right or left sided

---- Temple region

---- Frontal region

---- Base of skull with neck pain

---- Top of head

3. Quality of pain?

---- Throbbing

---- Stabbing

---- Aching

---- Pressure

4. Intensity of pain on a scale of 1-10?

5. Average duration of pain?

---- Minutes

---- Hours

---- Days

6. Frequency of Headaches?

---- Hourly

---- Daily

---- Weekly

7. Associated symptoms?

---- Nausea

---- Vomiting

---- Changes in vision such as: vision loss, blurry vision, double vision

---- Dizziness

---- Fainting spells

8. What makes your headaches better?

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9. What makes you headaches worse?

10. What is your average caffeine intake (coffee, tea, and/or soda) daily?

11. Are your headaches related to your menstrual cycle?

12. What medications do you take to stop your headaches, including over- the- counter medications?
 - Tylenol
 - Advil
 - Motrin
 - Exedrin Migraine
 - BC Powder

13. What medications have you tried for preventive treatment of headaches?
 - Inderal/propranolol
 - Topamax
 - Verapamil/Elavil/amitrypyline
 - SSRI's like Prozac, Effexor, Zoloft, Paxil, Celexa, Lexapro
 - Wellbutrin
 - Neurontin
 - Keppra
 - Tegretal
 - Muscle Relaxants

14. What triptans have you tried and their side effects?
 - Maxalt MLT
 - Migranal
 - Amerge
 - Frova
 - Imitrex
 - Zomig

15. Is your sleep pattern affected by your headaches? Please describe.

16. Do you have a family history of headaches?