



Headache Questionnaire

Name: _____

Date: _____

1. At what **age** did your headaches **begin**? _____

2. Does anyone in your family have chronic headaches? List below:

3. Have you had any history of head trauma? _____

4. How **often** do you have headaches per week, on average? _____

5. **Where** are your headaches typically located? _____

6. What **time of day** do they usually start (approximately), or does it vary a lot? _____

7. Is there anything that usually **triggers** your headache? Some typical triggers for headache are:
(check any that apply to you)

- | | |
|---|---|
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Citrus |
| <input type="checkbox"/> Menstrual period | <input type="checkbox"/> Too little or too much sleep |
| <input type="checkbox"/> Sexual intercourse | <input type="checkbox"/> Flashing lights |
| <input type="checkbox"/> Skipped meal | <input type="checkbox"/> Neck movement |
| <input type="checkbox"/> Alcoholic beverages esp. beer and wine | <input type="checkbox"/> Chocolate |

List any not listed here: _____

8. Do you have any **symptoms** other than pain with your headache? (check any that apply to you)

- | | |
|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Tingling or Weakness in Arms |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Tingling or Weakness in Legs |
| <input type="checkbox"/> Sensitivity to Light or Sound | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Visual symptoms just prior to, or with, your headaches | |

Describe: _____

List any not listed here: _____

There are two kinds of medicine for chronic headaches; **preventative** medicines that are taken on a **daily** basis to either prevent or at least lessen the frequency or severity of the headaches, and medicines that are taken on an **as needed** basis to **stop** the headache (hopefully) once it has started.

Please list below all daily preventative medicines that you have been on (if any) and whether it worked, and list any side effects of the medication.

Medication	Effect?	Side Effect (if any)
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Now please list any “as needed” medicines that you take now, or have taken in the past, to try to stop the headache, including prescription and over-the-counter medicines. As you did above, please list whether it works/worked, and any side effects.

Medication	Effect?	Side Effect (if any)
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Please write down everything you have eaten and drunk for the past 2 days. Continue on back if more space is required.

Food	Beverage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____