



Headache Questionnaire

Directions:

- Please answer the following questions regarding your headaches.
- If your answer is “yes” to any of the questions, please explain your answer.
- **You may skip areas that do not pertain to you.**

Patient name: _____

Age: _____ Male ___ Female Date: _____

Pattern and Description of Headaches

1. How long ago did your headaches begin? _____ Weeks ago _____ Months ago _____ Years ago

2. Are most of your headaches? _____ Mild _____ Moderate _____ Severe

3. How often do you have a headache? _____ Days per month _____ Never stops

4. Where are your headaches located on your head?

_____ Front R/L _____ No pattern _____ Everywhere

_____ Back R/L _____ I don't remember _____ Other

5. What does your headache feel like?

Pounding / throbbing _____ yes _____ no

Constant sharp sensation _____ yes _____ no

Little sharp stabs over and over for a
short time then it quits _____ yes _____ no

Dull sensation _____ yes _____ no

Pressure sensation “like a band” _____ yes _____ no

Can't really say _____ yes _____ no

6. How long do your headaches last? _____ Minutes _____ Hours _____ Days

7. Do you commonly have other symptoms with your headaches? (Mark all that apply to you)

Symptoms	Before Headache	During Headache	After Headache	How long do symptoms last?
ringing in ears				
Dizziness				
Imbalance				
Difficulty thinking				
Difficulty speaking				
Nausea or vomiting				
Body numbness				
Body weakness				
Sensitivity to light (you would prefer to be in a dark room when you have a headache)				
Sensitivity to sound (you would prefer not to be in a loud room when you have a headache)				
Vision changes(blurred vision, spots in your vision, patterns in your vision)				
Eye tearing				
Nasal drainage				
Change in pupil sizes (Is one pupil larger or smaller than the other?)				
Drooping of an eyelid				

8. Is there any particular time of day that your headaches are worse?

Morning
 Afternoon
 Evening
 During the night
 No real pattern

9. Are you aware of any triggers for your headaches, such as?

- Stress Yes No
- Sleep deprivation Yes No
- Physical exertion Yes No
- Dehydration (not drinking enough water) Yes No
- Heat Yes No
- Bright light Yes No
- Changes in weather Yes No
- Particular foods Yes No
- Skipping meals Yes No

Triggers for your headaches (continued)

Prolonged computer use _____ Yes _____ No
 Hormonal cycle (menstrual period) _____ Yes _____ No
 Excessive caffeine intake _____ Yes _____ No

Headaches and Other Symptoms

10. Have you had any of these other health or physical changes develop with or without a headache?

Other Symptoms	Yes	No	Describe further
Persistent weakness or numbness of a certain body part			
New onset seizures			
Change in balance or coordination			
Do your headaches worsen with coughing, sneezing or straining when you go to the bathroom?			
Significant changes with your vision: double vision or blurred vision?			
Significant change in academic performance?			
Significant Mood changes? What?			

11. Have you had any other new health complaints with your body besides headache? What?

12. Does your headache seem to come when you are in a certain position?

Headaches are worse when I have been lying down a long time: ___ Yes ___ No

Headaches are worse after I stand up: ___ Yes ___ No

13. Do you ever get a strange ringing or swooshing in your ears? ___ Yes ___ No

14. Do you ever taste blood in your mouth with physical activity? ___ Yes ___ No

Headaches associated with Head Injury
 (If this does not apply to you, go to next section)

14. Did a head injury trigger your headaches? ___ Yes ___ No

What happened?

15. When did the injury occur? _____

16. Did you injure your: ___ Head ___ Back ___ Neck ___ Whiplash

17. Did you resume play or resume normal activities after the injury?

___ Yes, immediately

___ No, unable to resume play/activities

___ Had to be carried/brought off playing field/area of accident

18. Were you unaware of your surroundings or experience amnesia? ___ Yes ___ No

If yes, Greater than 1 minute? Greater than 15 minutes?

19. Do you have to go to the emergency room or doctor's office because of headaches? Yes No

Explain:

Test results that were done:

Results of tests:

20. Did you have more intense headaches right after the injury? Yes No

Did the headaches start within 2 weeks of the head injury? Yes No

21. Have you had any increase of these symptoms since the accident?

Difficulty concentrating Yes No

Problems with balance Yes No

Fatigue Yes No

Mood changes Yes No

Decreased performance Yes No

Memory problems Yes No

Headaches associated with Infection

(If this does not apply to you, go to next section)

22. Did your headaches come on during or after an infection? Yes No

23. When was the infection? _____

24. Did you have any tests to document an infection such as:

Blood work (mono titers, blood count, etc)?

X-rays?

Lumbar puncture (needle put in your back to get fluid out)?

Please explain:

Headaches associated with Sinus and Allergy

(If this does not apply to you, go to the next section)

25. Do you have sinus or allergy symptoms? Yes No

26. What are your typical symptoms with your allergies or sinus symptoms?

None Yes No

Runny nose Yes No

Runny nose/itchy eyes Yes No

Drainage from my nose Yes No

Cough Yes No

Pressure symptoms on my face Yes No

27. Do these symptoms happen when you have most of your headaches? Yes No

If you answered yes, Often Rarely

28. Do you take certain treatments for sinus or allergy symptoms? Yes No

If you answered yes, what:

29. Do these treatments make your headaches better? Yes No Sometimes

30. Have you seen an allergist? Yes No

Results:

Headaches associated with Hormones

31. Did your headaches come on around the time of puberty? Yes No

32. If you are a girl, does your headache typically develop during a certain time in your menstrual period (if you have them yet)?

No, not really

Yes, typically during the week of my menstrual period

Yes, typically before or after my periods

33. Are you taking birth control pills or hormone treatment? Yes No

If you answered yes, please list what: _____

34. Has hormone treatment changed your headaches?

Hormone treatment have made the headaches better

Hormone treatments have made the treatments worse

Hormone treatments have made no changes in my headaches

This does not apply for me

Headache Treatment

Please indicate treatments below that you have tried for your headaches

35. Preventive medications (medications taken daily to prevent the headaches)

Medication	Please list the maximal dose of the medication that you have tried	Did this medicine help your headaches?
___ Propranolol (Inderal)		
___ Verapamil (Calan SR)		
___ Amitriptyline (Elavil)		
___ Nortriptyline (Pamelor)		
___ Depakote (Valproic Acid)		
___ Topamax (Topiramate)		
___ Neurontin (Gabapentin)		
___ Lyrica (Pregabalin)		
___ Keppra (Levetiracetam)		
___ Zonegran (Zonisamide)		
___ Periactin (Cyproheptadine)		

36. Abortive "Headache Attack" medications (medications taken to get rid of a headache)

Medication	Please list the maximal dose of the medication that you have tried	Did this medicine help your headaches?
___ Acetaminophen, Tylenol, Tylenol with codeine		
___ Ibuprofen, Advil, Motrin, Aleve, Toradol, Indomethacin		
___ Aspirin		
___ Excedrin, Excedrin Tension, Excedrin Migraine		
___ Cafegot, Migranol (Nasal spray)		
___ Midrin, Duradrin, Epidrin		
___ Fioricet, Fiorinal		
___ Maxalt (Rizatriptan)		
___ Imitrex (Sumatriptan)		
___ Relpax (Eletriptan)		
___ Amerge (Naratriptan)		
___ Axert (Almotriptan)		
___ Frova (Frovatriptan)		
___ Zomig (Zolmitriptan)		

37. In general, how many days of the week do you take a medicine (one of the above listed) to MAKE YOUR HEADACHE STOP?

___ Days per week

___ Days per month

38. Have you needed to receive IV treatments for your headaches in the Emergency Room or Hospital?

___ Yes ___ No

If yes, please indicate which treatments and if they helped:

___ Intravenous fluids Did it help: ___ Yes ___ No

___ Nausea medication Did it help: ___ Yes ___ No

___ Pain medication Did it help: ___ Yes ___ No

Name of medication:

___ DHE Did it help: ___ Yes ___ No

___ Other: _____ Did it help: ___ Yes ___ No

39. Alternative treatments used for headache

	Doses	Brand	How long taking?
Multivitamin			
Multimineral			
Magnesium			
Riboflavin (vitamin B2)			
Feverfew			
Petasites (Butterbur)			
Co-enzyme Q10			

Other treatments:

___ Physical therapy, how long? _____ did it help? _____

___ Massage therapy, how long? _____ did it help? _____

___ Chiropractic therapy, how long? _____ did it help? _____

___ Acupressure,/acupuncture, how long? _____ did it help? _____

___ Biofeedback training, how long? _____ did it help? _____

40. Prior Testing

Have you had any prior testing for your headaches? ___ Yes ___ No

Please bring a copy of the results with you to the visit.

Test	Date of test	Indicate if you know the results
Magnet resonance imaging (MRI)		
Computed tomography (CT)		

Electrocardiogram (EKG)		
Electroencephalogram (EEG)		
Vision testing		
Labwork		

41. Past Medical History

Current Medications:

Birth complications:

Serious or chronic illnesses:

Overnight hospitalizations:

Surgeries:

Head or neck injuries:

42. Review of Health Systems

Do you have any problems with any of the following? If "yes," please explain

Recent change in height or weight? ___Yes ___No	Lungs (breathing problems, asthma) ___Yes ___No
Skin (rashes) ___Yes ___No	Stomach (bowel movement) ___Yes ___No
Eyes (vision) ___Yes ___No	Urination ___Yes ___No
Ears (hearing), nose (allergies) ___Yes ___No	Muscles or bones ___Yes ___No
throat (tonsils)	
Mouth (dental/orthodontic) ___Yes ___No	Blood or immune system ___Yes ___No
Heart (palpitations, murmurs) ___Yes ___No	Endocrine or reproductive (menstrual) ___Yes ___No

43. Child Development and School

What school do you attend?

What grade are you in?

Do you like school? ___Yes ___No

Have you had any difficulties with learning? ___Yes ___No

If yes, please explain:

What type of classes are you in?

___ Special education

___ Remedial

___ Regular

___ Honors

___ Advanced placement/international baccalaureate/talented and gifted

How is your school performance?

Have you had any recent change in your school performance?

If yes, please explain why you think this has happened:

44. Family Medical History	
Condition	Please indicate who in the family may have the condition:
Headaches or migraines	
Motion sickness	
Seizure disorders or epilepsy	
Mood disorders (such as depression, anxiety, panic, bipolar disorders)	
Learning disorders	
Blood clotting disorders (clots in the legs or lungs, strokes, frequent miscarriages)	
Thyroid disorders	
Autoimmune disorders (lupus, rheumatoid arthritis, juvenile diabetes)	

45. Social History

Who do you live with:

___ Both parents ___ One parent ___ Parent and step-parent ___ Legal guardian

___ Foster parent ___ Adoptive parent

How many siblings (brothers and sisters) do you have?

Has there been any recent stress in the home (such as a recent move, divorce, or death in the family)?

Have you ever intentionally hurt yourself or others? ___ Yes ___ No

Have you ever been in trouble with the law? ___ Yes ___ No

Do you smoke tobacco, drink alcohol, or experiment with drugs? ___ Yes ___ No

Are you sexually active? ___ Yes ___ No

46. Core Health Questions

Exercise

How often do you exercise? ___ days per week

What do you do for exercise and for how long typically?

Relaxation

How do you relax?

Do you wish you had more time to relax? ___ Yes ___ No

Sleep

How many hours of sleep do you obtain on weekdays? ____

Do you have any problems falling asleep or staying asleep? ___Yes ___No

Do you snore? ___Yes ___No

Do you grind your teeth? ___Yes ___No

Diet

How is your appetite?

Do you skip meals often (such as breakfast)? ___Yes ___No

How many 8 oz glasses of water, juice, or milk do you drink per day?

Do you drink any caffeinated beverages, such as soda, coffee, or tea? ___Yes ___No

If yes, how much do you drink per day or per week?

Electronic Use

How many hours a day do you text or talk on the phone? ____hours per day

How many hours per day are you on the computer? _____

How much of the daily computer use is for true work or homework? _____

Is "surfing" the internet or emailing the main way you relax? ___yes ___no

47. Questions for Us

Please mark below some areas you may want to learn more about.

___What kind of headaches do I have?

___How I can stop my headache when the attack occurs?

___Do I need further workup for my headaches?

___I want to learn about other treatment options besides medicine.

___Other: _____

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