Mid Maryland Neurology

Initial Visit Headache Questionnaire

Name: ______________________________ **Date:** ____________________

Onset:

At what age did you start having headaches? ________

Frequency:

How many total days a month do you have some form of headache? (all headaches) _______

How many days in the past month did you take pain medicine? ________(***including*** OTCs Excedrin, Tylenol, etc.)

How often do your headaches occur?

_____ X /Day _____ X /Week _____ X /Month _____ X /Year ❑ Constant

How long ago did the *current* headache start? (if constant) ______

Has your headache pattern changed in the last three to six months? How? ______________________________

____

Duration:

How long does a typical headache last?

_____ Seconds _____ Minutes _____ Hours _____ Days ❑ Constant

Quality of Pain

How would you best describe the quality of the pain? *Check all that apply*

Throbbing/pulsating	Pressing/squeezing	Stabbing	Dull/nagging	Other
❑	❑	❑	❑	❑

Does the headache ever waken you from sleep? ❑ Yes ❑ No

Location:

On what part of your head does the headache start?

❑ Left	❑ Right	❑ Both sides	❑ Around eye	❑ All over
❑ Front	❑ Back			

Severity:

Mark down the number of headaches each month that are:

Mild _____ Moderate _____ Severe _____

How would you grade the severity of your *average* headache?

❑ 1(least) ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑10(worst)

Associated Symptoms:

❑ Nausea
❑ Vomiting
❑ Light sensitivity
❑ Noise sensitivity
❑ Loss of vision
❑ Flashing lights
❑ Visual blurring
❑ Double vision
❑ Tearing
❑ Nasal congestion
❑ Drooping eyelid
❑ Strange visual patterns (zigzags, sparkling, shimmering or colored lights)
❑ Difficulty speaking
❑ Difficulty understanding
❑ Numbness
❑ Weakness
❑ Dizziness/vertigo
❑ Do you ever have ***warning symptoms*** 20 to 30 minutes prior to a headache? ❑ Yes ❑ No
❑ Other?

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Triggers:

Check any of the following that seem to bring on your headaches.

- ❑ Menstrual cycle
- ❑ Insufficient sleep
- ❑ Change in weather
- ❑ Loud noises
- ❑ Exertion
- ❑ Sex
- ❑ Missed meals
- ❑ Odors
- ❑ Stress
- ❑ Bright lights
- ❑ Alcohol
- ❑ Motion Sickness
- ❑ Other:
- ❑ Foods: (list)

Treatment:

Have you tried the following ***abortive*** headache medications. *Check if used*

Medication	*Effective?*	*Side effects (if any)*
❑ Sumatriptan (Imitrex, Sumavel)	❑ Yes ❑ No	
❑ Sumatriptan and Naproxyn (Treximet)	❑ Yes ❑ No	
❑ Rizatriptan (Maxalt)	❑ Yes ❑ No	
❑ Almotriptan (Axert)	❑ Yes ❑ No	
❑ Elatriptan (Relpax)	❑ Yes ❑ No	
❑ Zolmatriptan (Zomig)	❑ Yes ❑ No	
❑ Naratriptan (Amerge)	❑ Yes ❑ No	
❑ Frovatriptan (Frova)	❑ Yes ❑ No	
❑ Dihydroergotamine (Migranal or DHE)	❑ Yes ❑ No	
❑ Prednisone	❑ Yes ❑ No	
❑ Isometheptene/dichloralphenazone (Midrin)	❑ Yes ❑ No	
❑ Ketorolac: Toradol, Sprix	❑ Yes ❑ No	
❑ NSAIDs: ibupofen/naproxyn/diclofenac	❑ Yes ❑ No	
❑ Others:		

Have you tried the following ***preventative*** headache medications. *Check if used*

Medication	*Effective?*	*Side effects (if any)*
❑ Amitriptyline, nortriptyline	❑ Yes ❑ No	
❑ Propranolol, metoprolol, atenolol	❑ Yes ❑ No	
❑ Depakote	❑ Yes ❑ No	
❑ Topiramate	❑ Yes ❑ No	
❑ Verapamil	❑ Yes ❑ No	
❑ Zonisamide	❑ Yes ❑ No	
❑ Botox	❑ Yes ❑ No	
❑ Others?	❑ Yes ❑ No	

Tests:

Check all tests you have had for your headaches

Test	*Date*	*Results*
❑ MRI head		
❑ MRI C-spine		
❑ CT head		
❑ EEG		
❑ Spinal tap		
❑ Blood work		