

# Neurology Headache Questionnaire

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

1. Did the headaches start after an accident, illness or infection?
2. How long has the patient had these headaches?
3. Are the headaches constant or do they come and go?
4. How often do the headaches occur? (daily, weekly, monthly)
5. Do the headaches occur at a certain time of the day? \_\_\_\_\_ morning \_\_\_\_\_ afternoon \_\_\_\_\_ night
6. Are the headaches becoming stronger, lasting longer or occurring more frequently?
7. Do the headaches ever wake up the patient up when he is sleeping?
8. Does rest or sleep relieve the headache?
9. Do the headaches stop the patient from doing things? (like playing, watching TV, going outside or doing homework.)
10. Has the patient ever missed school or work because of a headache?
11. Is the headache pain intense when it starts, or does it start out small and builds up?
12. Please check all of the things that **bring on the headaches:**

<input type="checkbox"/> Odors (Perfume, cigarettes)	<input type="checkbox"/> Fatigue	<input type="checkbox"/> School
<input type="checkbox"/> Hunger (missing meals)	<input type="checkbox"/> Loud noises	<input type="checkbox"/> Anxiety or stress
<input type="checkbox"/> Exercise or playing	<input type="checkbox"/> Ice Cream	<input type="checkbox"/> Family problems
<input type="checkbox"/> Too much sleep (sleeping in)	<input type="checkbox"/> Bright Lights	<input type="checkbox"/> Menstrual cycles
<input type="checkbox"/> Too little sleep (staying up late)	<input type="checkbox"/> Sunshine	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/> Riding in a car	<input type="checkbox"/> Hot weather	<input type="checkbox"/> Alcohol (wine, beer)

Medications Which ones? \_\_\_\_\_

Certain foods Which ones? \_\_\_\_\_

(for example: chocolate, peanut butter, eggs, milk, pizza, etc.)
13. Are nasal congestion, sinusitis or allergies associated with the headache?
14. Are there any warning signs **BEFORE** the headache begins?

<input type="checkbox"/> Paleness	<input type="checkbox"/> Mood swings (either high or low)	<input type="checkbox"/> Irritability
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Tired, sleepy, or yawning	<input type="checkbox"/> Increased appetite
<input type="checkbox"/> Rings around the eyes	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Craving sweets
<input type="checkbox"/> Eye problems (like blurred vision, black spots, flashing lights, or double vision)		

15. Where is the headache located?

- Left side
- Right side
- Neck
- Forehead
- Temples
- Back of the head
- All around the head
- Top of the head

If the pain is another part of the head please describe or mark the location:



16. What does the pain feel like?

- Throbbing or pounding (like a hammer)
- Tightness (like a rubber band wrapped around the head)
- Dull
- Aching

- Exploding
- Sharp
- Pressure

Please describe the pain in your own words:

17. Are there any other symptoms when the patient has a headache?

- Nausea
- Vomiting
- Stomach pains
- Confusion
- Weakness in the arms or legs
- Numbness in the arms or legs

If there are any other symptoms, please describe them:

18. Who else in the family has had headaches, migraines, sick headaches, motion sickness, "brain freeze" from eating ice cream or had trouble taking Birth Control Pills because of headaches?

19. Describe any stresses in the last year

(such as separation, divorce, job changes, moves, death in the family, or poor grades).

20. Who has treated the patient for headaches? When were they treated?

What tests were done?

- CT scan
- MRI
- Spinal Tap
- Eye Exam
- Dental exam
- Allergy tests
- Sinus X-rays
- Allergy Tests
- Blood tests etc.)

Any other tests?:

21. What medications or treatments have you tried? (glasses, allergy shots, chiropractor, **herbal medicines**, Motrin, Tylenol, prescription medicines, etc.)

23. What questions do you have about the patient's headaches? What worries you the most? What medical tests, medicines or therapies do you want to know about?