Headache History & Profile Questionnaire

NAME:_____ DATE:_____

- On what part of the head do the headaches start? Use diagrams to shade areas of pain:

☐ (R)Side ☐ (L)Side ☐ Either Side ☐ Both Sides
☐ Back ☐ On top ☐ Temples ☐ Behind/Around eyes
☐ Forehead ☐ Face ☐ Neck ☐ Other - _____

- How long ago did the current headaches start? ____ Weeks ____ Months ____ Years
- How old were you when any headache started? ____
- How long does the headache usually last? ____ Minutes ____ Hours ____ Days ____ Constant
- How often does the headache occur? ____ x/Day ____ x/Week ____ x/Month ____ x/Year ____ Constant
- Is the headache getting - ☐ More Severe ☐ More Frequent ☐ Both
- After the headache starts - Does it usually: ☐ Stay in one Place ☐ Move around Please explain - _____
- How would you describe the pain? ☐ Throbbing/pulsating ☐ Pressing/Squeezing ☐ Stabbing ☐ Sharp ☐ Dull/nagging ☐ Other - _____
- Describe the degree of pain when your headaches start: - slight - 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ - worst imaginable
- Describe the degree of pain with most of your headaches: - slight - 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ - worst imaginable
- Describe the degree of pain with your worst headache: - slight - 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ - worst imaginable
- Do your headaches interfere or prevent normal activities - work etc.? ☐ Yes ☐ No
- Has your productivity at Work or School been affected by your headache(s)? ☐ Yes ☐ No
- In the last month have your headaches caused you to miss: Leisure activities / Work / School? ☐ Yes ☐ No
- In the past 6 months have your headaches caused you to miss: Leisure activities / Work / School? ☐ Yes ☐ No
- Do any blood relatives have severe headaches? ☐ Yes ☐ No If Yes, Who & Diagnosis? - _____
- Do you have any history of Head or Neck injury? ☐ Yes ☐ No
- If Yes, Did this involve a loss of consciousness? ☐ Yes ☐ No
- Which of the following makes the headache better? ☐ Rest ☐ Activity ☐ Darkness ☐ Quiet ☐ Hot compress ☐ Pregnancy ☐ Menopause ☐ Cold Compress ☐ Scalp or temple pressure

Lifestyle:

- Do you exercise regularly? ☐ Yes ☐ No If Yes, How often?_____ What?_____
- Do you frequently skip meals? ☐ Yes ☐ No
- How much caffeine do you eat/drink in a day? (e.g. coffee, tea, soda, chocolate) _____
- Social History - Cigarettes (#day / #yrs.) ____/____ Alcohol (oz. / day) ____/____ Coffee (cups / day) ____/____
- Do you have any problems sleeping? ☐ Yes ☐ No
- Does the headache awaken you from sleep? ☐ Yes ☐ No
- Do you wake feeling rested? ☐ Yes ☐ No
- Are you or have you been - ☐ Depressed ☐ Anxious

Associated Headache Symptoms:

• Are any of the following symptoms associated with the headache? Please mark: (B) before (X) during (A) after

___ Spots before eyes - type - ___ Blindness (R / L) ___ Blurring (R / L) ___ Eyelid droop (R / L)

___ Can see only half of objects ___ Tearing (R / L) ___ Double Vision ___ Eye redness (R / L)

___ Eyes puffy (R / L) ___ Light sensitivity ___ Noise sensitivity ___ Odor sensitivity

___ Nose blocked / discharge (R / L)

___ Nausea ___ Vomiting ___ Stomach Cramps ___ Hunger

___ Loss of appetite ___ Diarrhea

Face - Scalp -

___ Pale ___ Redness ___ Sweating ___ Tender

___ Pain on chewing ___ Puffy ___ Decreased jaw opening

Neck -

___ Stiff ___ Tender

___ Depression ___ Fatigue ___ Anxiety ___ Irritability

___ Difficulty concentrating ___ Difficulty talking (finding words) ___ Difficulty understanding

___ Fainting (feel like or have fainted) ___ Slurred speech ___ Dizzy (lightheaded - unsteady - Spinning)

Hands and / or feet -

___ Cold ___ Pale ___ Sweaty ___ Mottled

Weakness(W) Numbness(N) Both(B)

___ Face(R / L) ___ Arms(R / L) ___ Legs(R / L) ___ Arm & Leg (R / L)

___ Numbness around lips

Indicate if any of the following factors have (+) brought on (trigger) or (++) worsen your headache -

___ Sleep - too much - too little ___ Sexual activity ___ Chocolate ___ Medications(list)

___ Emotional stress - during - after ___ Missed meal ___ Citrus fruits ___ Menstrual Periods

___ Depression - anxiety ___ Change in weather ___ Cheeses ___ Pregnancy

___ Physical activity ___ Seasons - ___ MSG ___ Menopause

___ Erect Position ___ Alcohol ___ Other foods(list) ___ Oral Contraceptives

___ Bending Over ___ Processed meats ___ Straining - coughing