



HEADACHE QUESTIONNAIRE

NAME _____

DATE _____

PLEASE DESCRIBE YOUR HEADACHES

- When did your headaches start? #_____ days ago, #_____ weeks ago, #_____ months ago, #_____ years ago
- Did your headache start after a head injury? No Yes, describe injury _____
- How many days in a month do you have a headache? _____ How many headache-free days do you have in a month? _____
- Where are your headaches located in general? **check all that apply**
 - TEMPLE **Right Left Both** EAR **Right Left Both** EYE **Right Left Both** OTHER _____
 - AROUND HEAD NECK TOP OF HEAD **Right Left Both** _____
 - FRONT OF HEAD JAW BACK OF HEAD **Right Left Both** _____
- Your headaches usually feel like: **check all that apply**
 - THROBBING SHOOTING PULSING
 - ACHY BURNING TIGHT
 - DULL STABBING OTHER _____
- How long do your headaches last in HOURS? _____ Shortest _____ Longest _____ Average
or are they constant? Yes No
- Your headaches are worse in the:
 - MORNING EVENING NO PATTERN
 - AFTERNOON DURING THE NIGHT
- Do you have other symptoms during your headache? **mark all that apply**
 - NAUSEA OR UPSET STOMACH/VOMITING
 - SENSITIVITY TO LIGHT (*PREFER A DARK ROOM*)
 - SENSITIVITY TO SOUND (*PREFER A QUIET ROOM*)
 - SORE/STIFF NECK
 - VISION CHANGES (*BLURRED, SPOTS, PATTERNS*)
 - EYE TEARING IN ONLY *ONE EYE*
 - RUNNY NOSE IN ONLY *ONE NOSTRIL*
 - RINGING IN EARS
 - EYE-REDNESS **Right Left Both**
 - DROOPING EYELID **Right Left Both**
 - SWELLING OF EYELID **Right Left Both**
 - CHANGE IN PUPIL (*LARGER SMALLER*)
 - DIZZINESS/VERTIGO
 - IMBALANCE
 - NUMBNESS/TINGLING **Right Left Both** WHERE? _____
 - STROKE LIKE SYMPTOMS (*facial droop, droopy eyelid, unable to move one arm or leg*)
 - SENSITIVITY TO SMELLS
 - DIFFICULTY THINKING/CONCENTRATING/FOCUS
 - DIFFICULTY SPEAKING/SLURRED SPEECH
 - INCREASED URINATION
 - ANXIETY
 - IRRITABILITY
 - MEMORY PROBLEMS
 - INCREASED APPETITE
 - DECREASED APPETITE
 - DIARRHEA
 - CONSTIPATION
 - INSOMNIA
 - SLEEPINESS
 - CONFUSION



9. AURA: Do you have these symptoms before your headache begins?

- VISUAL** FLASHING LIGHTS ZIGZAG LINES TOTAL BLINDNESS LOSS OF VISION IN ONE EYE
 WAVY LINES DOUBLE VISION SPOTS: BRIGHT/DARK LOSS OF VISION ON ONE SIDE
 TUNNEL VISION GEOMETRIC FORMS DISTORTED VISION OTHER _____

- SENSORY AND OTHER** LIGHTEADEDNESS ONE-SIDED WEAKNESS *Right Left Both* DIZZINESS/UNSTEADINESS
 SPEECH DIFFICULTY NUMBNESS/TINGLING *Right Left Both* CONFUSION/DEJA VU/HALLUCINATIONS
 VERTIGO OTHER _____

10. Have you needed to go to the hospital or emergency room (ER) for headaches? Yes No

If yes, how many times in the last 6 months? _____

11. Have you been treated with any of the following?

AIMOVIG YES NO EMGALITY YES NO ANJOVY YES NO

If yes, when was your last injection? _____

Have you been treated with any of the following?

ANTIDEPRESSANTS

- AMITRIPTYLINE
- CITALOPRAM
- DOXEPIN
- FLUOXETINE
- FLUVOXAMINE
- MIRTAZAPINE
- NORTRIPTYLINE
- PAROXETINE
- PROTRIPTYLINE
- SERTRALINE
- VENLAFAXINE

ANTIEPILEPTICS/

ANTICONVUSANTS

- DIVALPROEX SODIUM
- GABAPENTIN
- TIMOLOL
- TOPIRAMATE
- VALPROIC ACID

BETA-BLOCKERS

- ATENOLOL
- METOPROLOL
- NADOLOL
- PROPRANOLOL

CALCIUM CHANNEL

BLOCKERS

- DILTIAZEM
- NIFEDIPINE
- NIMODIPINE
- OVERAPAMIL

ACE INHIBITORS

- CANDESARTAN
- ENALAPRIL
- IRBESARTAN
- LISINAPRIL
- LOSARTAN
- LOMESARTAN
- RAMIPRIL
- VALSARTAN

NSAIDS/ANALGESICS

- ACETAMINOPHEN
- ASPIRIN
- DICLOFENAC
- IBUPROFEN
- NAPROXEN

TRIPTANS

- ELETRIPTAN
- ERGOTAMINE
- FROVATRIPTAN
- NARATRIPTAN
- RIZATRIPTAN
- SUMATRIPTAN
- ZOLMITRIPTAN

COMBINATION/OTHER

- ACETAMINOPHEN/ASPIRIN/CAFFEINE ASPIRIN
- BUTALBITAL/ACETAMINOPHEN/CAFFEINE
- BUTALBITAL/ASPIRIN/CAFFEINE
- BUTORPHANOL
- ERGOTAMINE/CAFFEINE
- SUMATRIPTAN/NAPROXEN