**HEADACHE MEDICINE** **Name** _____

**NEW PATIENT QUESTIONNAIRE** **Date** _____

Age your headaches began _____ (or how long ago did they start? _____)

Do you have more than one type of headache? □ Yes □ No

*If yes*, answer the following questions about *your most disabling headache type.*

Do you get any of the following symptoms hours to days before the headache starts?

□ Food cravings or hunger □ Unexplained mood change □ Uncontrollable yawning

□ Excessive thirst □ Excessive urination □ Drowsiness □ Euphoria □ Other _____

What parts of your head and neck hurt? _____

What does it feel like (aching, throbbing, etc)? _____

How often do your headaches occur? _____

How long do they last? On average _____ Longest _____ Shortest _____

How severe is your pain? Mild _____Moderate _____ Severe _____

Do you have any warning before the pain starts (aura)? □ Yes □ No

If yes, describe _____

Do you have any of the following **with your headaches** (check all that apply):

□ Nausea or inability to eat □ Worsening with activity (walking, climbing stairs)

□ Vomiting □ Numbness or tingling □ Ringing in ears

□ Sensitivity to light □ Weakness on one side of the body/face

□ Sensitivity to noise □ Difficulty speaking □ Imbalance

□ Sensitivity to odors □ Confusion □ Spinning dizziness

□ Diarrhea □ Tearing from the eye(s) □ Double vision

□ Stuffy nose □ Bloodshot eye(s) □ Droopy eyelid

□ Runny nose □ Restlessness □ Other _____

Do your headaches ever awaken you from sleep? □ Yes □ No *If yes*, at what time? _____

Do you have to/prefer to lie down with your headaches? □ Yes □ No

Do any of the following worsen your headaches?

□ Coughing □ Sneezing □ Laughing □ Lifting □ Straining or bearing down

□ Sexual activity

Are your headaches better at any particular time of the day? _____

Are your headaches worse at any particular time of day? _____

Is your headache severity affected by lying down, sitting or standing? _____

Have you identified anything that triggers your headaches? □ Yes □ No

*If yes*, list: _____

_____

Describe: _____

Have your headaches caused problems in any of the following areas of your life?

□ Job □ Housework □ School □ Home life □ Relationships □ Social life □ Legal

Women: Do any of the following affect your headaches? □ Ovulation □ Menstrual period □ IUD

□ Birth control pill □ pregnancy □ menopause □ hormone replacement therapy

Explain: _____

On average, how many days monthly are you *headache-free*? _____

Have you had a brain CT or MRI? □ Yes □ No (*If yes*, **bring films or CD with you**)

How much caffeine do you consume? _____

In what form □ Coffee □ Tea □ Soda □ Chocolate □ Excedrin or medication

Do you use or consume foods or beverages containing Nutrasweet/Equal/aspartame? □ Yes □ No

How much sleep do you get every night on average? _____ hours

Have you ever been told that you stop breathing or gasp during sleep? □ Yes □ No
Have you ever been diagnosed with sleep apnea? □ Yes □ No

Have you ever had a concussion? □ Yes □ No Details: _____

Have you ever been physically, sexually or emotionally abused? □ Yes □ No
Are you currently in an abusive relationship? □ Yes □ No

Do any family members have migraines or "sick headaches"? □ Yes □ No

If so, whom? _____

Do any family members have cluster headaches? □ Yes □ No

If so, whom? _____

What medications have you tried for *acute (symptomatic) treatment* of headache (you took it when you got a headache)? Include medications for nausea and over-the-counter. If you can't remember, try and get your pharmacy records and bring them with you.

| Medication | Dose (mg) | How long ago/when? | Was it effective? | Side effects |
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What medications have you tried for prevention of headache?
(pills, injections or infusions)

| Medication | Highest dose taken (mg) | How long did you use it? | Was it effective? | Side effects |
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Have you used any neuromodulation devices? ☐ No

| Name of Device | How long did you use it? | Was it effective? | Side effects |
|---|---|---|---|
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Have you been diagnosed with:

| | In the past (resolved) | Currently have it |
|---|---|---|
| Fibromyalgia | _____ | _____ |
| Irritable bowel syndrome | _____ | _____ |
| Pelvic pain | _____ | _____ |
| Temporomandibular disorder (TMJ) | _____ | _____ |
| Painful bladder syndrome | _____ | _____ |
| Bipolar disorder | _____ | _____ |
| Joint hypermobility | _____ | _____ |
| Ehlers-Danlos syndrome | _____ | _____ |
| POTS | _____ | _____ |
| Polycystic ovary syndrome (PCOS) | _____ | _____ |