NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC.
a division of unity health network

Headache Questionnaire

Patient's name:_____ D.O.B. _____
Age:_____ Sex:_____ Right/Left handed _____
Race/Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other: _____
_____

1. My Headaches started approximately at age: ____
2. Did your headaches start after a head /neck trauma? ○ Yes..... ○ No
3. Did your headaches start after an illness or infection? ○ Yes..... ○ No
4. I think I have more than one type of headache: ○ Yes..... ○ No

5. My typical headache:
☐ usually starts in one side but it can spread to the other side
☐ usually starts in both sides or my entire head from the beginning
☐ Starts in the back of my head or neck area
☐ Starts from back of the eye(s) or nose /sinus area
☐ **Always** starts in one side and stays at the same side: ○ Right:.....; ○ Left:

6. At the onset of a headache or even before headache starts, sometimes I experience:
☐ Some visual changes:
○ Blurry vision with both eyes ○ Blurry vision with just one eye
○ seeing dots and lines (Squiggly lines, jagged lines, sparkly dots, colored dots,...)
○ Tunnel vision ○ Double vision
☐ Numbness or tingling in **one side** of my body: ( ) Cheek ( ) tongue ( ) arm ( ) leg
☐ Difficulty speaking ☐ word-finding difficulty with or without confusion
☐ Weakness in **one side** of my body: ( ) Face ( ) arm ( ) leg
☐ Ear ringing ☐ Hearing difficulty ☐ difficulty walking

7. I describe most of my headaches (specifically severe ones) as:
☐ throbbing (feeling of pulsation or heartbeat inside the head)
☐ Sharp (stabbing)
☐ Jabbing and Jolting (electric shock-like)
☐ Pressure sensation ☐ Dull ache ☐ Band-like sensation around my head
☐ Exploding

8. My headache usually associated with: (or sometimes even before headache starts)
☐ Nausea ☐ Vomiting ☐ Stomach discomfort ☐ loss of appetite ☐ food cravings
☐ Dizziness: ( ) lightheadedness ( ) room spinning ( ) balance issue ☐ excessive thirst
☐ Sensitivity to light ☐ Sensitivity to noise ☐ Sensitivity to smell(s): what kind?.....
☐ Excessive urination ☐ diarrhea ☐ yawning ☐ excessive fatigue
☐ Tearing (watering) of eye: ( ) one eye ( ) both eyes ☐ Runny nose
☐ Droopy eye: ( ) one eye ( ) both eyes ☐ Agitation, restlessness (ex. pacing back and fourth)

9. I think my headaches are sometimes triggered by:
☐ Stress ☐ Sleep disturbance (too much or too little sleep) ☐ missing a meal
☐ Weather changes ☐ Barometric pressure changes ☐ Flickering or glaring light
☐ Alcohol ☐ Menstrual cycle: ( ) before flow ( ) during flow ( ) after flow
☐ Certain foods, please specify:.....☐ Certain smell(s):.....
☐ Other, please explain:.....

10. Once my headache has begun, it can be worsened by:
☐ Any kind of exertion, even going up or down stairs
☐ Bending over or lifting objects ☐ Straining/coughing/sneezing
☐ laying down ☐ Standing up ☐ Cold temperatures ☐ Hot temperatures

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11. My typical headache usually lasts about ..... hours.

12. I've had headaches which lasted 3 days or more: ○ Yes ○ No

13. On average how many days per month do you experience any kind of headache? .....

14. On average how many days per month do you experience severe headaches which prevents you from doing your normal daily activities (e.g, missing work) ? .....

15. On a scale of 0 to 10 (which 0 means no headache and 10 means worst possible pain *(like brain surgery without anesthesia)* how would you rate your average intensity of your headache?.....

16. I have:
☐ No problem with my sleep ☐ Difficulty falling sleep ☐ Difficulty maintaining my sleep ☐ snoring
☐ awakening at nights due to breathing difficulty ☐ Lack of sleep ☐ too much sleep
☐ awakening at the middle of nights due to headache ☐ waking up with headache in the morning

17. Do you have/have had in the past any of the following condition:
☐ Anxiety ☐ Depression ☐ Bipolar ☐ ADD (Attention deficit) ☐ Suicidal ideation or attempt
☐ Seizure ☐ Childhood asthma ☐ motion sickness ☐ head injury ☐ concussion
☐ Heart palpitation (racing) ☐ Chest pain or tightness ☐ recreational drug use
☐ High blood pressure ☐ Low blood pressure ☐ Raynaud's phenomenon
☐ Other, please explain _____

18. Have you had any fever or chills which accompany your headaches? ○ Yes ○ No
19. Any recent ○ weight gain or ○ weight loss? ○ No ○ Yes: how much?.....

20A. Please list any medication(s) which you've taken as an acute **(as needed)** treatment for your headaches. *Please indicate the dose if you remember and also whether it was effective.*

Medication name	Dose	Was in effective

20B. Please name the preventative (**daily**) medication(s) you take/have taken for your headaches in the past. *Please indicate the dosage (if you remember) and duration for which you used each one. If you had side effects from the medication please also explain them.*

Medication name	Dose	How long did you take it?	Side effects

Print Name _____ D.O.B. _____

Patient Signature _____ Date _____