HEADACHE QUESTIONAIRE

Patient Name: _____ **Telephone #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Age:** ___ **Sex M or F Have you ever been seen at this clinic? Y or N**

How long have you suffered from migraines? (years) _____

Sensitive to light?	**Yes or No**
Sensitive to sound?	**Yes or No**
Nausea?	**Yes or No**
Vomiting?	**Yes or No**
Throbbing pain on one side of your head?	**Yes or No**
Is your daily routine disturbed due to your headache pain?	**Yes or No**
Do you ever need to go to bed or lie down due to your headache?	**Yes or No**

Before your headache begins, do you ever see spots in front of you or have visual disturbances? Yes or N

Do you have tingling in your hands or face? Yes or No

Do you ever have slurred speech? Yes or No

If you experience any of these symptoms you may have Aura.

Ho many headaches do your experience a month? _____

How would you rate the level of pain: Mild _____ **Moderate** _____ **Severe** _____

Have you ever had a pain free interval? Yes of No If yes, how long? _____
(this would mean a period of time without headaches)

Family history of recurrent headaches affecting at least one parent, grandparent, brother or sister or children? _____

Have you ever been referred to a specialist for headache? Yes or No
If yes, date and name of doctor seen: _____

Have you ever been to the Emergency room for a headache? Yes or No
If yes, how often? _____

Treatment given: _____

List all medication, past and present, taken to treat your headaches:

_____

_____

List all medication taken for other medical reasons:

_____

Do you experience irritability 24 hours prior to a headache? Yes or No
FEMALES ONLY:
Do your headaches occur during your menstrual period? Or before? _____