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Headache Patient Questionnaire

1. How often do you get headaches bad enough to interfere with your daily activities & how long do they last?

2. How often do you get milder headaches and how long do they last?

3. How old were you when you **first recall** having any kind of headache?

4. Has there been a **significant change** in your headaches recently?

5. How often do you **miss work or social activities** due to headaches?

6. How **often** do you take headache **relievers or pain pills**?

7. Are your headaches sometimes accompanied by (circle all that apply):
    a. Nausea
    b. Vomiting
    c. Sensitivity to light
    d. Sensitivity to sound
    e. Sensitivity to odor

6. Are your headaches sometimes associated with (circle all that apply):
    a. Seeing zig-zag lines
    b. Having a blind spot
    c. Losing vision to one side
    d. Sensation of room spinning
    e. Things look too big or too small
    f. You pass out or come close to it
    g. You go numb on one side
    h. You get weak on one side

7. Is your headache pain sometimes (circle all that apply):
    a. Made worse with movement/activity
    b. One-sided
    c. Pounding
    d. Stabbing
    e. Throbbing
    f. Pressure

8. Do you have any of the following with your headaches?
    c. Ringing ears
    e. Neck pain
    f. Tender scalp

11. Have you noticed any **mental status changes**? (circle all that apply):
    a. Confusion
    b. Disorientation
    c. Sudden forgetfulness
    d. Easily agitated

12. Have you had any **walking problems** or clumsiness?
    a. Yes
    b. No

13. Are your headaches **accompanied by**? (circle all that apply):
    a. Nasal stuffiness
    b. Redness of eye(s)
    c. Drooping eyelid(s)
    d. Easily agitated

14. Is your headache onset after **strenuous physical exercise or sex**?
    a. Yes
    b. No

15. Are your headaches **produced** (not just worsened) by **straining**, such as with a bowel movement?
    a. Yes
    b. No

16. Have your headaches had a recent **change in pattern**?
    a. Yes
    b. No

17. Have your headaches **worsened** over the past 4 weeks **despite medications** that previously worked?
    a. Yes
    b. No

18. Do your headaches occur with a **sudden onset**?
    a. Yes
    b. No

19. Do you have a history **of brain swelling** (Pseudotomor Ceribri or other)?
    a. Yes
    b. No

20. Do you have a history of **head trauma** within the past year?
    a. Yes
    b. No

21. Do your headaches **frequently awaken** you at night?
    a. Yes
    b. No