New Patient Headache Questionnaire

Name:____Primary Care Provider___________________________________

Please describe your headaches:

1. **When did your headaches start?** #____days ago, #______weeks ago, #_____months ago, #_____years ago
2. **Did your headache start after a head injury?** ◯ No ◯ Yes →if yes, describe injury_____________________________
3. **Did your headache start after an infection?** ◯ No ◯ Yes → if yes, what infection? ____________________________
4. **Did your headache begin when you started or changed a medication?** ◯ No ◯ Yes →if yes, which medication? _________________________
5. **Do you smell things others don't smell?** ◯ No ◯ Yes
6. **Have you ever had any significant head trauma?** ◯ No ◯ Yes
7. **Do you have a history of concussions?** ◯ No ◯ Yes
8. **Do you ever have Deja'Vu?** ◯ No ◯ Yes
9. **Do you ever have Jama'Vu?** ◯ No ◯ Yes
10. **Do you have periods where you lose track of time?** ◯ No ◯ Yes
11. **Do you have episodes of anxiety for no reason?** ◯ No ◯ Yes
12. **Do you have vivid dreams?** ◯ No ◯ Yes
13. **Do you have sleep paralysis?** ◯ No ◯ Yes
14. **Do you have uncontrollable body movements?** ◯ No ◯ Yes
15. **How many days** in a month do you **have a headache?**______How many **headache-free days** do you have in a month?____________
16. **How severe are your headaches?** (from 0 to 10=most severe pain possible): On average #____Most severe # ____
17. **Do you have more than one type of headache?** ◯ Yes ◯ No If yes, focus the following questions on your worst disability headache type.
18. **Where are your headaches located in general?** (check all that apply)

◯ Temple -- R L
◯ Back of head -- R L
◯ Top of head -- R L
◯ Other _____________________
◯ Front of head
◯ Around head
◯ Eye -- R L
◯ Ear-- R L
◯ Neck
◯ Jaw

19. **Your headaches usually feel like**: (check all that apply)

◯ Throbbing/Pulsing ◯ Dull ◯ Shooting
◯ Achy ◯ Stabbing ◯ Burning
◯ Tight ◯ Pressure ◯ Other ____________________

20. **How long do your headaches last in <u>HOURS</u>?** Shortest____Longest____Average_____or are they constant? Yes No

21. **Your headaches are worse** in the ◯ morning ◯ afternoon ◯ evening ◯ during the night ◯ no pattern

22. **Are your headaches worse lying down or standing?** ___________________

23. **Do your headaches wake you up in the middle of the night?** ◯ Yes ◯ No; if yes, how often? ______________

24. **Premonitory symptoms** (you experience one or more of these symptoms 1 to 2 days before onset of headache)

◯ Hyperactive ◯ Difficulty with speech ◯ Food cravings ◯ Other
◯ Depressed feeling ◯ Sensitive to light ◯ Increased appetite
◯ Irritability ◯ Sensitive to sound/noise ◯ Decreased appetite
◯ Feeling sluggish ◯ Dizziness ◯ Increased urination
◯ Difficulty concentrating ◯ Excessive yawning ◯ Stiff neck

25. **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 [R L Both]
◯ Swelling of eyelid [R L Both]
◯ Change in pupil [Larger Smaller]
◯ Dizziness/vertigo
◯ Imbalance
◯ Confusion
◯ Stroke like symptoms (facial droop, droopy eye lid, 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
◯ Numbness/Tingling [R L Both] where?_____________
◯ Other

26. **Aura**: (Do you have these symptoms before your headache begins?)_

Visual

◯ Flashing lights ◯ Loss of vision in one eye ◯ Tunnel vision ◯ Spots: bright/dark
◯ Zigzag lines ◯ Loss of vision on one side ◯ Double vision ◯ Geometric forms
◯ Wavy lines ◯ Total blindness ◯ Distorted vision ◯ Other: ___________

Sensory and other:

◯ Numbness/tingling [R L Both] ◯ Light headedness
◯ Speech difficulty ◯ One-sided weakness [R L Both]
◯ Vertigo ◯ Confusion/déjà vu/hallucinations
◯ Dizziness/unsteadiness ◯ Other: _______________________

If you have any of these symptoms above, they usually last:_____minutes and terminate_____minutes before pain starts
OR occur ◯ during the head pain ◯ after the head pain ◯ without the head pain

27. **Provoking Factors** (Triggers = things that bring on a headache)

Food/beverage: ◯ Fasting/skipping meals ◯ Chocolate ◯ Caffeine ◯ Nitrates ◯ MSG ◯ Aged cheese

◯ Alcohol beverages: ◯ Wine: [Red White] ◯ Other:____________________________

Physical exertion: ◯ Coughing ◯ Talking ◯ Chewing ◯ Exercise ◯ Sexual intercourse

Hormonal: Menses ◯ Before ◯ During ◯ After; ◯ Pregnancy ◯ Menopause

Stress: ◯ Work ◯ Home ◯ Family ◯ Spouse ◯ Other: _________________________________

Environmental: ◯ Allergies ◯ Weather changes ◯ Altitude ◯ Sunlight ◯ Other: ______________________

Sleep: ◯ Lack of sleep ◯ Too much sleep ◯ Change in wake/sleep

Other Triggers: ____

28. **Activity that worsens headache:**

◯ None ◯ Walking ◯ Climbing steps ◯ Exercise ◯ Other

29. **Relieving Factors:**

◯ Lying down ◯ Dark quiet room ◯ Hot compress ◯ Massage
◯ Standing ◯ Ice/Cold compress ◯ Keeping active/pacing ◯ Pregnancy
◯ Other:

30. Which **Acute medications** have you tried (medications taken to stop a headache)?

Acute (as needed) medication	On average, how many days per week?	Did it help? YES/NO	Currently taking? YES/NO
Acetaminophen (Tylenol)			
Aleve (Naprosyn, Naproxen)			
Almotriptan (Axert)			
Aspirin			
Baclofen (Lioresal)			
Celecoxib (Celebrex)			
Cyclobenazeprine (Flexeril)			
Diclofenac (Cambia)			
Dihydroergotamine (Migranal, DHE)			
Diphenhydramine (Benadryl)			
Eletriptan (Relpax)			
Excedrin			
Fioricet, Fiorinal			
Frovatriptan (Frova)			
Ibuprofen (Advil/Motrin)			
Indomethacin (Indocin)			
Ketorolac (Toradol)			
Lidocaine nasal spray			
Metaxalone (Skelaxin)			
Metoclopramide (Reglan)			
Midrin (Duradrin, Epidrin)			
Naratriptan (Amerge)			
Ondansetron (Zofran)			
Prochlorperazine (Compazine)			
Promethazine (Phenergan)			
Rizatriptan (Maxalt)			
Sumatriptan (Imitrex)			
Tizanidine (Zanaflex)			
Tramadol (Ultram)			
Vicodin, Codeine, Demerol, Percocet			
Zolmitriptan (Zomig)			
Other:			

31. **Preventive medications** (taken daily to prevent headaches)

Preventive (daily) medication	Approximate Dose/day	How long did you take it? Weeks/Months/Years	If stopped, why? No benefit/Side effects/Other
Amitriptyline (Elavil)			
Candesartan (Atacand)			
Gabapentin (Neurontin)			
Lamotrigine (Lamictal)			
Lisinopril (Zestril)			
Metoprolol (Lopressor)			
Methylergonovine (Methergine)			
Nortriptyline (Pamelor)			
Pregabalin (Lyrica)			
Propranolol (Inderal)			
Topiramate (Topamax)			
Valproic Acid (Depakote)			
Venlafaxine (Effexor)			
Verapamil (Calan SR)			
Zonisamide (Zonegran)			
Other:			

32. **Have you needed to go to the hospital or emergency room (ED) for headaches?** ◯ Yes ◯ No
If yes, how many times in the last 6 months? __________

33. **Have you been treated in the infusion clinic for your headaches**? ◯ Yes ◯ No
If yes, how many times in the last 6 months? __________

What did you receive in the ED or Infusion clinic?	Did it help? YES/NO	If headache returned, how long after treatment?
IV cocktail		
DHE (dihydroergotamine)		
Pain medication (narcotics)		
Steroid		
Other:		

34. **Behavioral and Alternative treatments used**

Supplements	Did it help?	How long did you take it? (Ws/Ms/Ys)	Behavioral/Physical therapy	Did it help?	How long did you take it? (Ws/Ms/Ys)
Multivitamin/multi mineral			Psychologist, therapist		
Riboflavin (vitamin B2)			Physical therapy		
Magnesium			Massage		
Co-enzyme Q10			Chiropractic therapy		
Melatonin			Acupressure/puncture		
Petasides (Butterbur)			Biofeedback		
Iron			Yoga		
Feverfew			Other:		

35. **Procedures used** (check all that apply):

Occipital nerve blocks: ◯ R ◯ L
Auriculotemporal nerve blocks: ◯ R ◯ L
Botox injections: #_____Last______months ago

Supra-orbital/Supra-trochlear nerve block: ◯ R ◯ L
Head/Neck injections under X-ray guidance: ◯ Yes ◯ No
Other procedures ___________________________________

36. **Do you have any health issues involving?**

Other medical problems	Yes	No	If yes, describe		Yes	No	If yes, describe
Change in height or weight				Endocrine or reproductive			
Skin, including herpes, shingles				Blood or immune system			
Eyes (vision)				Muscles or bones			
Ears, nose, throat				Neurologic (seizures, other)			
Mouth (dental/orthodontic)				Depression			
Heart (palpitations, murmurs)				Anxiety			
Lungs (breathing issues/asthma)				ADHD			
Stomach (bowel movements)				Substance abuse			
Urination				Other:			

37. **Core Health Questions**

Exercise

How often do you exercise?______days per week
How long do you typically exercise?________minutes
What do you do for exercise? ____

Relaxation

How do you relax? ____
Do you wish you had more time to relax? ◯ Yes ◯ No
Have you had any training in relaxation techniques? ◯ Yes ◯ No

Sleep

On shorter nights, how long does it take you to fall asleep?______minutes
How many hours do you sleep a night?__________hours
Do you have any problems falling asleep? ◯ Yes ◯ No
Do you have any problems staying asleep? ◯ Yes ◯ No
Do you snore? ◯ Yes ◯ No Have you ever been told you have sleep apnea? ◯ Yes ◯ No
Do you grind your teeth? ◯ Yes ◯ No

Diet

How is your appetite? ◯ excellent ◯ good ◯ okay ◯ not good ◯ awful
Do you skip meals often? ◯ Yes ◯ No
How many 8oz glasses of water, juice, or milk do you drink per day?_____glasses per day
Do you drink caffeinated beverages (soda, coffee, or tea)? ◯ Yes ◯ No; if yes how much____servings per week

38. **Testing**

Have you had brain and/or cervical spine MRI or CT? ◯ Yes ◯ No If yes, please make images/report available to your provider for appointment

Have you had lumbar puncture (spinal tap)? ◯ Yes ◯ No If yes, please make report available to your provider for appointment