Duke Neurology of Raleigh
Headache Questionnaire

Date: ___________________  Patient Name: ___________________

Basic Questions:

1. On how many days in the last 3 months did you miss work or school because of your headaches?

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

6. At what age do you remember your first significant headache?

7. When was the last day you were headache free?

8. When was the last time you had 6 headache-free days in a row?

9. How often do you have to go to the Emergency Room for headaches?

10. When your headaches first started, do you remember getting some relief by changing positions from sitting to lying? Yes or No

11. What other physicians have you seen for headaches/facial pain?
12. Have you ever been admitted to the hospital for your headaches?

13. Have you tried chiropractic care or acupuncture for your headaches? Yes or No

14. What studies have you had for your headaches?
   a. MRI of head: Y/N Approximate date and place of procedure:
   b. CT scan of head: Y/N Approximate date and place of procedure:
   c. MRI of neck: Y/N Approximate date and place of procedure:
   d. Spinal Tap: Y/N Approximate date and place of procedure:

15. Do you snore? Y or N
16. Do you clench or grind your teeth at night? Y or N
17. Have you been diagnosed with TMJ disorder? Y or N
18. Does your neck hurt during the headaches? Y or N
19. Does your neck hurt when you don't have a headache? Y or N
20. Do you drink caffeinated beverages? Y or N
   If yes, how many a day? ______

21. Do you have high blood pressure? Y or N
22. Do you suffer from sinusitis? Y or N
23. Have you made any dietary changes to decrease your headaches? Y or N

Past Headache Treatment:

Circle any of the medicines below that you tried before to stop headaches once they start:

<table>
<thead>
<tr>
<th>Immitrex</th>
<th>Relpax</th>
<th>Zomig</th>
<th>Toradol</th>
<th>Hydrocodone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maxalt</td>
<td>Prova</td>
<td>Emerge</td>
<td>Migranal</td>
<td>Axert</td>
</tr>
<tr>
<td>Esac</td>
<td>Floricet</td>
<td>Fiorinal</td>
<td>Butalbital</td>
<td>Midrin</td>
</tr>
<tr>
<td>Tylenol</td>
<td>Aleve</td>
<td>Advil</td>
<td>Cafergot</td>
<td>Indesin</td>
</tr>
<tr>
<td>Treximet</td>
<td>Ergotamine</td>
<td>Excedrin</td>
<td>Goody/BC powders</td>
<td></td>
</tr>
</tbody>
</table>

Other medicines used to stop headaches:
Circle all of the medicines below you have used for prevention of headaches/facial pain:

Gabapentin (Neurontin)  Topamax  Amitriptyline (Elavil)  Nortriptyline (Pamelor)  Lamictal
Zonegran (zonisamide)  Lyrica  Depakote  Tegretol (carbamazepine)  Baclofen
Verapamil  Cyproheptadine  Prozac (fluoxetine)  Effexor (venlafaxine)
Naproxen (Aleve)  Cymbalta  Keppra  Inderal (propranolol)
Toprol (metoprolol)  Atenolol

Other medicines used for headache prevention:

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Part 3: Headache Details:

How many types of headaches do you have? Fill out the information on this page and the next page for each type of headache you have.

Headache #1
1. Mark the areas where your head hurts for this headache type:

   [Diagram showing headache areas: Right, Back, Left]

2. Have you had this headache type for less than 3 months? Y or N

3. How would you describe the pain? (examples: throbbing, squeezing, dull, tightness, stabbing, shooting)
4. Do you have nausea with this headache? Y or N
5. Do you have sensitivity to light with this headache? Y or N
6. Do you have sensitivity to sound with this headache? Y or N
7. Do you have sensitivity to smell with this headache? Y or N
8. Do you have changes in your vision before/during this headache? Y or N
9. Has this headache changed recently? Y or N If so, how has it changed?
10. What time of day are these headaches the worst?
11. What medicines have helped this headache?

12. Circle any of the aggravating factors below:

<table>
<thead>
<tr>
<th>Caffeine</th>
<th>Too Much Sleep</th>
<th>Too Little Sleep</th>
<th>Weather changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>Aspartame</td>
<td>Chocolate</td>
<td>Strenuous activity</td>
</tr>
<tr>
<td>Monosodium glutamate (MSG)</td>
<td>Talking</td>
<td>Chewing</td>
<td>Menstrual period</td>
</tr>
<tr>
<td>Altered eating schedule</td>
<td>Alcohol Intake</td>
<td>Neck Movement</td>
<td></td>
</tr>
</tbody>
</table>

Headache #2 (If you only have 1 type of headache, you are finished)

13. Mark the areas where your head hurts for this headache type:
14. Have you had this headache type for less than 3 months? Y or N

15. How would you describe the pain? (examples: throbbing, squeezing, dull, tightness, stabbing, shooting)

16. Do you have nausea with this headache? Y or N

17. Do you have sensitivity to light with this headache? Y or N

18. Do you have sensitivity to sound with this headache? Y or N

19. Do you have sensitivity to smell with this headache? Y or N

20. Do you have changes in your vision before/during this headache? Y or N

21. Has this headache changed recently? Y or N  If so, how has it changed?

22. What time of day are these headaches the worst?

23. What medicines have helped this headache?

24. Circle any of the aggravating factors below:

Caffeine   Too Much Sleep   Too Little Sleep   Weather changes
Stress     Aspartame        Chocolate        Energetic activity
Monosodium glutamate (MSG)   Talking        Chewing          Menstrual period
Altered eating schedule      Alcohol Intake  Neck Movement