DukeMedicine

EXTRAORDINARY PEOPLE. EXTRAORDINARY CARE.

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:

Imitrex	Relpax	Zomig	Toradol	Hydrocodone
Maxalt	Frova	Amerge	Migranal	Axert
Esgic	Fioricet	Fiorinal	Butalbital	Midrin
Tylenol	Aleve	Advil	Caffergot	Indocin
Treximet	Ergotamine	Excedrin	Goody/BC powders	

Other medicines used to stop headaches:

_____

_____

Circle all of the medicines below you have used for <u>prevention</u> 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 (alleve)	Cymbalta		Keppra	Inderal (propranolol)
Toprol (meloprolol)			Atenolol	

Other medicines used for headache prevention:

_____

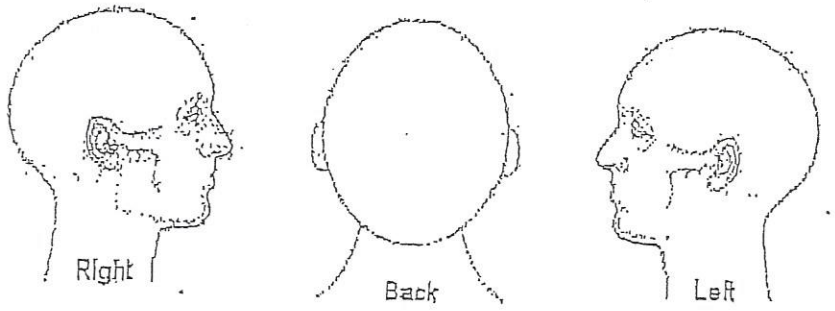
_____

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:



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?

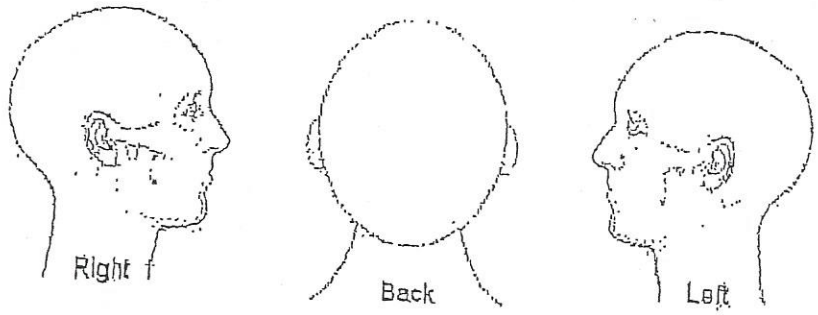
_____

12. Circle any of the aggravating factors below:

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

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?

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

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23. What medicines have helped this headache?

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24. Circle any of the aggravating factors below:

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