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HEADACHE HISTORY FORM

PATIENT NAME: _____ **DATE:** _____

Please fill out this questionnaire as best you can; your answers provide valuable information, but remember, there are no "right" or "wrong" answers!

If you have *more than one type* of headache, do the following answers apply to your:
_____most frequent headache type _____most troublesome headache or ___both?

1. Onset of headache:
My headaches started _____years ago or _____months ago (if less than one year).
I was ____ under 20 _____ 20-39 _____ 40-60 _____ over 60 years old.

Changes in headaches: ___ no significant change
My headaches became ___ more frequent ___ less frequent ___ more intense ___ less intense when?
___ years ago ___ months ago

2. Location: *My headaches occur:* _____ only on one side ____on either or both sides
Primarily where? ____all over my head____over my temples ____neck or back of the head
____ eyes ____ sinuses. Other location: _____

3. Description: *How would you typically describe the pain of your headache?*
_____throbbing, pounding or pulsating ____dull, steady aching
_____pressure, tightness or squeezing ____Other:_____

4. Intensity: My head pain is typically: ____ mild ____ moderate ____ severe ____ unbearable

5. Duration:
When untreated, my headaches typically last ____minutes - hours - days (circle one)
When treated, my headaches typically last ____minutes - hours - days (circle one) ____ never treated

6. Frequency:
My headaches occur *roughly* ____ times per day - week - month - year (circle one)
Do your headaches usually occur at the same time of day or night? If so, when?_____

7. Other symptoms: *Do any of the following occur before or during your headache?*

	Before	During		Before	During
Blurred vision	_____	_____	Neck pain	_____	_____
Seeing flashes or spots	_____	_____	Nausea	_____	_____
Eyes sensitive to light	_____	_____	Vomiting	_____	_____
Sensitive to noise	_____	_____	Fever	_____	_____

Other: _____

Typically during my headache, _____I can continue working ____I must lie down (check one)

8. Other factors: *Does anything consistently bring on your headache?*
____ fatigue ____ stress/tension ____ certain moods ____exertion ____ weather
____ bending ____ lying down ____ reading ____ lack of sleep _____menstruation
____ certain beverages:_____

____ certain foods:_____
____ other:_____

Does anything (besides medication) *relieve* your headache? If so, describe:_____

_____

9. Treatments:

a. List any over-the-counter medications, herbal supplements or vitamins that you take specifically for headaches and circle the ones that help: _____

_____

b. List *prior* and *current* prescription medications and dosages you have tried for headaches on **Page 3.**

c. List any other treatments you may have tried specifically for your headaches:

_____ _____

_____

d. In the past 12 months, how many times have you needed to visit an ER for your headache? _____ In the past 12 months, how many days of work or school have you missed due to your headaches?_____

10. List doctors who have treated you for your headaches, *beginning with the most recent:*

1. _____ Specialty _____ 3. _____ Specialty _____

2. _____ Specialty _____ 4. _____ Specialty _____

11. List any tests performed specifically for your headaches: ___ vision testing ___CT scan of brain ___ Brain MRI scan ___ Sinus x-rays ___ Allergy testing ___ Spinal tap
Other: _____ _____

12. Other history:

a. Does/did any parent or sibling of yours have persistent headaches? ____No ____Yes

b. Did you have any serious head or neck injury in the past? If so, please provide the year(s) and a brief description:_____

c. Do you drink caffeinated beverages? ___No ___Yes. How many per day?_____

d. Have you been experiencing any of the following?
____ depressed mood ____ lack of sleep or excessive fatigue ____ excessive physical or emotional stress

13. What do you think is the cause of your headache? _____

_____

Thank you again. Please also fill out the "Neurology Clinical Summary" questionnaire.

Patient name:_____ **Date of birth:**_____

Prior Headache medications:

Drug name	approx. dates used	highest dosage	times per day	effect on headache	Side effects (if any)

Current Headache medications:

Drug name	approx. dates used	highest dosage	times per day	effect on headache	Side effects (if any)