

Headache questionnaire

When did you start getting headaches? _____

What part of your head do your headaches affect? _____

Quality? ___ Pounding ___ Pressure ___ Sharp Other _____

How many headaches do you have in a typical week? _____

Do you always have some headache? _____

How many headache free days do you have per month? _____

How long do your headaches last? _____ hours _____ days

Do you have some headaches that are more severe than your typical headache? _____

If yes, how often do you have these more severe headaches? _____

Do you have neck pain that brings on your headaches? _____

Do you have nausea with your headaches? _____ Vomiting? _____

Do you ever have changes in your vision (twinkling, spots, etc) with headaches? _____

Do you ever have changes in your hearing (ringing, etc) with headaches? _____

Do you have light sensitivity with your headaches? _____ Sound? _____

What makes them better? _____ Worse? _____

Do they wake you up from sleep? _____ Have you had an MRI of your brain? _____ When? _____

Have you had PT for headaches? _____ Did it help? _____

Have you had injections for headaches? _____

Which ones? _____ Did they help? _____

For the following medications:

	On now	Tried/Haven't tried	Helped/Didn't help	Side-effects
Tylenol	_____	_____/____	_____/____	_____
Ibuprofen(Advil/Motrin)	_____	_____/____	_____/____	_____
Naproxen(Aleve)	_____	_____/____	_____/____	_____
Opioid(Tramadol/hydro/oxy)	_____	_____/____	_____/____	_____
Gabapentin	_____	_____/____	_____/____	_____
Lyrica	_____	_____/____	_____/____	_____
Cymbalta/Effexor	_____	_____/____	_____/____	_____
Triptans/imitrex/relpax	_____	_____/____	_____/____	_____
Beta-blockers(propranolol)	_____	_____/____	_____/____	_____
Ca-ch blockers (verapamil)	_____	_____/____	_____/____	_____
TCAs(ami/nortriptyline)	_____	_____/____	_____/____	_____
Topomax/Carbamazepine	_____	_____/____	_____/____	_____