Scripps Clinic

DALESSIO HEADACHE CENTER
HEADACHE QUESTIONNAIRE

Name_____ Age_____

Date_____ Gender _____

Headache History

How old were you when you had your first significant headache? _____

Have you been given a headache diagnosis? If so, what? _____

_____

What do you think causes the headaches? _____

_____

Family History

Has anyone in your family had a significant problem with headaches or been diagnosed as having migraine or "sick" headaches? No Yes (If yes, who?)

_____

Headache Characteristics

Over the past month, how many days of any type of headache did you have?_____

How many different types of headache do you have?

1. Type/location_____ Frequency per month_____

2. Type/location_____ Frequency per month_____

3. Type/location_____ Frequency per month_____

How long does a typical headache attack last?

a) 0-1 hr b) 1-6 hr c) 6-24 hr
d) 2 days e) constant f) too variable

Has there been any recent change in the character or frequency of your headaches and if so what? : _____

Check any of the following factors which seem to trigger a headache attack for you:

- ☐ alcohol (specify types:)_____
- ☐ menstruation
- ☐ emotional stress
- ☐ odors (please list:) _____
- ☐ fatigue
- ☐ missing meals
- ☐ caffeine
- ☐ changes in weather
- ☐ physical activity
- ☐ positional change
- ☐ changes in sleep
- ☐ other (please specify:) _____

Are your headaches ever incapacitating (e.g., have to leave work or school or lie down undisturbed)? No Yes

How many days per month are you incapacitated by headache? _____

Have you had to visit a hospital, ER or Urgent care in the past 6 months because of headache?_____

How severe is your typical (average) headache ?
☐ Mild ☐ Moderate ☐ Severe

Overall, how disabled do you feel you have been by headaches over the past month?
☐ Mild ☐ Moderate ☐ Severe

Is your headache pain ever throbbing? No Yes Unknown

Is your headache ever localized to one side? No Yes Unknown

Does your headache always occur on the same side? No Yes

Does your headache typically occur during:

a) a certain time of day?
b) a certain season
c) weekends, holidays and vacations
d) a certain time of the month?

Do you have any symptoms which alert you that you are going to have a headache attack? No Yes (If yes, what type do you have?)

_____

Do you ever experience any of the following symptoms in association with your headache attacks (before, during, or after)? Please check the appropriate boxes:

- ☐ nasal congestion
- ☐ nausea
- ☐ vomiting
- ☐ diarrhea
- ☐ visual changes (e.g.s, visual distortion, "flash cubes", "zig-zags", "blind spots", "sparkles"). (Please describe:). _____
- ☐ inability to tolerate bright light (photophobia)
- ☐ inability to tolerate loud noise (phonophobia)
- ☐ numbness and/or tingling in face, arm, or leg (Please describe:). _____
- ☐ weakness of the face, arm or leg (Please describe:) _____
- ☐ speech disturbance (Please describe:). _____
- ☐ loss of balance
- ☐ vertigo (i.e., a spinning/"merry-go-around" sensation)
- ☐ extreme thirst, food cravings (Please describe:). _____
- ☐ loss of consciousness
- ☐ neck tenderness
- ☐ worsens with routine physical activity such as climbing stairs

History of Sleep

a) My ideal amount of sleep is _____ hours.

1. During the week I usually:
   Go to bed at _____(time)
   Get up at _____ (time)
   Sleep_____(hours)
2. During the weekend I usually:
   Go to bed at _____(time)
   Get up at _____ (time)
   Sleep_____(hours)

	Yes	No
b) I awaken from sleep with headache:	____	____
c) Sleep helps my headache:	____	____
d) Oversleeping produces headache:	____	____

e) I snore: nightly____ weekly_____ rarely _____ never _____

f) After a typical nights sleep, I feel: refreshed_____ fairly rested_____ somewhat tired_____ very drowsy_____

g) I often have difficulty falling asleep Yes___ No___ or staying asleep Yes___ No___

h) **Epworth Sleepiness Scale**

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. (Even if you have not done some of these things recently, try to work out how they would have affected you.) Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of Dozing
1) Sitting and reading	_____
2) Watching TV	_____
3) Sitting inactive in a public place (For example; theatre)	_____
4) As a passenger in a car for an hour without a break	_____
5) Lying down to rest in the afternoon when circumstances permit	_____
6) Sitting and talking to someone	_____
7) Sitting quietly after lunch without alcohol	_____
8) In a car, while stopped for a few minutes in traffic	_____
Total	_____

Medical History

Do you consider yourself to be currently under a significant amount of stress? No Yes

Do you adhere to a regular exercise program? No Yes

Do you eat at regular intervals? No Yes

Are you currently receiving formal treatment (counseling and/or medications) for anxiety or depression? No Yes

Please check the appropriate boxes:
- ☐ history of thyroid disease
- ☐ treated for depression in past
- ☐ past or present problems with significant motion sickness
- ☐ do you smoke cigarettes now? (Number of cigarettes per day)
- ☐ any significant head injury? (if yes, within the past six months? No Yes)
  any neck injury or whiplash?

Have you taken oral contraceptives or estrogen replacement therapy in the past or present? No Yes

(If yes, effect on your headaches? Better worse no change can't recall)

If you have been pregnant, what effect did the pregnancy have on your headaches? Better worse no change can't recall

Are you currently pregnant? No Yes (If yes, effect on your headaches? Better Worse No change)

Have you had a CAT scan in the past? No Yes unknown

Have you had a brain MRI scan in the past? No Yes unknown

Treatment History

Please estimate how many days per month you take any medication(s) for your headaches? _____

Have you tried other treatments for headaches:
Biofeedback_____Relaxation techniques_____ Chiropractic_____
Physical therapy_____Acupuncture/pressure_____Ice/cold compresses_____Other_____

Headache Medication (Painkillers) Tried-Nonprescription

	Past	Current	Dose	# of tabs/ headache
Aspirin	___	___	___	___
Acetaminophen (Tylenol)	___	___	___	___
Ibuprofen: (Advil, Nuprin, Motrin IB)	___	___	___	___
Aleve (Naprosyn)	___	___	___	___
Excedrin	___	___	___	___
Sinus remedies	___	___	___	___
Other _____	___	___	___	___

Headache Medication (Painkillers) Tried-Prescription

	Past	Current	Dose	# of tabs per headache
Fiorinal/Fioricet	___	___	___	___
Cafergot	___	___	___	___
Migranol	___	___	___	___
D.H.E. 45	___	___	___	___
Midrin	___	___	___	___
Imitrex	___	___	___	___
Amerge	___	___	___	___
Treximet	___	___	___	___
Frova	___	___	___	___
Zomig	___	___	___	___
Maxalt	___	___	___	___
Axert	___	___	___	___
Relpax	___	___	___	___
Ultram	___	___	___	___
Toradol	___	___	___	___
Tylenol with Codeine	___	___	___	___
Stadol NS	___	___	___	___
Demerol	___	___	___	___
Morphine	___	___	___	___
Vicodin/hydrocodone	___	___	___	___

Prevention Medications Tried

	Past	Current	Dose
Propanolol (Inderal)	___	___	___
Tenormin (Atenolol)	___	___	___
Verapamil (Calan)	___	___	___
Amitriptyline (Elavil)	___	___	___
Nortriptyline (Pamelor)	___	___	___
Valproic Acid (Depakote)	___	___	___
Topiramate (Topamax)	___	___	___
Levetiracetam (Keppra)	___	___	___
Gabapentin (Neurontin)	___	___	___
Zonisamide (Zonegran)	___	___	___
Pregabalin (Lyrica)	___	___	___
Protriptyline (Vivactil)	___	___	___
Sinequan (Doxepin)	___	___	___
Duloxetine (Cymbalta)	___	___	___
Venlafaxine (Effexor)	___	___	___
Botulinum A toxin (Botox)	___	___	___
Zanaflex (Tizanidine)	___	___	___

Others

_____	___	___	___
_____	___	___	___
_____	___	___	___