OHSU HEADACHE CENTER

Headache questionnaire

Date:	Referring physician:
Last name:	First name:
Your age:	How old were you when your headache started?
How often do you have headaches: PER ◯ WEEK ◯ MONTH	
Are they continuous? ◯ YES ◯ NO	How long does each headaches last?
Did you have car or motion sickness as a child? ◯ YES ◯ NO	
What is the intensity of your headache? ◯ MILD ◯ MODERATE ◯ SEVERE	
What is the quality of your headache? ◯ THROBBING / PULSATING ◯ PRESSURE-LIKE ◯ STABBING	
Where your headaches are usually located?	◯ RIGHT SIDE ◯ LEFT SIDE ◯ BOTH SIDE
	◯ BEHIND THE EYES ◯ TEMPLE ◯ FOREHEAD ◯ TOP OF THE HEAD
	◯ IN THE BACK OF THE HEAD ◯ NECK
Do you have any of the following symptoms with your headaches?	◯ NAUSEA ◯ LIGHT SENSITIVITY ◯ SOUND SENSITIVITY ◯ SMELL SENSITIVITY ◯ TOUCH SENSITIVITY ◯ FATIGUE ◯ DIZZINESS ◯ DIFFICULTY CONCENTRATING ◯ YAWNING ◯ RED EYE ◯ TEARY EYE ◯ SWOLLEN EYELID ◯ DROOPY EYELID ◯ RUNNY NOSE ◯ FEELING CONGESTED
Have you experienced any of the following symptoms before or during your headaches?	◯ BLURRY VISION ◯ FLASHING LIGHTS ◯ WIGGLY LINES ◯ HALO LIGHTS AROUND OBJECT ◯ OTHER VISUAL SYMPTOMS:
	NUMBNESS OR TINGLING IN ◯ FACE ◯ ARM ◯ LEG
	WEAKNESS IN ◯ FACE ◯ ARM ◯ LEG
	◯ DIFFICULTY SPEAKING ◯ SLURRED SPEECH ◯ DIFFICULTY FINDING YOUR WORDS
When you experience a headache, do you:	◯ WANT TO BE STILL / NOT MOVING ◯ WANT TO PACE / FEEL RESTLESS ◯ MOVEMENT DOES NOT MATTER
Are you headache worse with: ◯ LAYING DOWN ◯ STANDING UP ◯ BENDING OVER	
Do you know of any trigger for your headaches?	◯ EXERCISE ◯ SKIPPING MEALS ◯ MENSTRUATION ◯ ALCOHOL ◯ AIR TRAVEL ◯ ALTITUDE CHANGE ◯ STRESS ◯ SLEEP DEPRIVATION ◯ DEHYDRATION ◯ WEATHER CHANGE ◯ OTHER:
Did you ever hit your head and lost consciousness?	◯ YES ◯ NO If yes, how old were you?

Does anyone in your family have headaches?

◯ MOTHER ◯ FATHER ◯ SISTER ◯ BROTHER ◯ AUNT
◯ UNCLE ◯ GRANDFATHER ◯ GRANDMOTHER ◯ SON
◯ DAUGHTER ◯ OTHER:

Do any of these conditions run in your family?

◯ STROKE ◯ HEART DISEASE ◯ CANCER ◯ SEIZURE
◯ OTHER:

How often do you exercise? TIMES PER WEEK

What type of exercise do you do?

What time do you go to bed?

What time do you wake up?

Do you have difficulty falling asleep? ◯ YES ◯ NO

or sleeping through the night? ◯ YES ◯ NO

Do you snore? ◯ YES ◯ NO

Have you ever woken up gasping for air? ◯ YES ◯ NO

How many cups of caffeine (coffee, soda, tea) do you drink? PER ◯ DAY ◯ WEEK

Do you drink alcohol? ◯ YES ◯ NO

If yes, how many drinks? PER ◯ DAY ◯ WEEK

Do you smoke cigarettes? ◯ YES ◯ NO

If yes, how many cigarettes? PER DAY

Have you ever had a lumbar puncture (also known as a spinal tap)? ◯ YES ◯ NO

Have you ever had a brain MRI? ◯ YES ◯ NO If yes, make sure to bring reports/CD to your visit.

Have you ever had a sleep study? ◯ YES ◯ NO

If yes, do you use a CPAP machine? ◯ YES ◯ NO

Do you any other medical problems?

What medication(s) do you currently take?

Have you tried any other these medications/interventions in the past?

◯ ACUPUNCTURE ◯ AMERGE ◯ AMITRIPTYLINE ◯ ATENOLOL ◯ AXERT ◯ BACLOFEN ◯ BOTOX ◯ CAMBIA ◯ CANDESARTAN
◯ CELEBREX ◯ CYMBALTA ◯ DEPAKOTE ◯ DEXAMETHASONE ◯ FLEXERIL ◯ FROVA ◯ GABAPENTIN ◯ IMITREX
◯ INDOMETHACIN ◯ IV DHE ◯ KEPPRA ◯ LAMICTAL ◯ LYRICA ◯ MAXALT ◯ MEDITATION / MINDFULNESS
◯ MEDROL DOSE PACK ◯ METOPROLOL ◯ MIGRANAL NASAL SPRAY ◯ MOBIC ◯ NAMENDA ◯ NAPROXEN ◯ NORTRIPTYLINE
◯ OCCIPITAL NERVE BLOCK ◯ OXYGEN SUPPLEMENT ◯ PHYSICAL THERAPY ◯ PROPRANOLOL ◯ PREDNISONE ◯ RELPAX ◯ SAVELLA
◯ TEGRETOL ◯ TOPAMAX ◯ TRIGGER POINTS INJECTION ◯ TRILEPTAL ◯ VENLAFAXINE ◯ VERAPAMIL ◯ ZANAFLEX ◯ ZOMIG
◯ ZONISAMIDE

Were any of these effective? ◯ YES ◯ NO

If yes, which one(s)?

In the last few weeks, have you experienced any of these symptoms?

◯ ABDOMINAL BLOATING ◯ ABDOMINAL PAIN ◯ BACK PAIN ◯ BLURRED VISION ◯ CHEST PAIN ◯ CONSTIPATION ◯ DIARRHEA
◯ DIFFICULTY WITH BALANCE ◯ DIFFICULTY WITH MEMORY ◯ DIFFICULTY WITH URINATION ◯ DIZZINESS ◯ DOUBLE VISION
◯ FATIGUE ◯ FEELING ANXIOUS ◯ FEELING DEPRESSED ◯ FEVER ◯ HEART PALPITATION ◯ ITCHING ◯ JOINT PAIN ◯ NAUSEA
◯ NECK PAIN ◯ NUMBNESS ◯ RAPID HEARTBEAT ◯ RAYNAUD'S PHENOMENON ◯ SEXUAL DYSFUNCTION ◯ SKIN RASH
◯ SWOLLEN JOINT ◯ TINGLING ◯ TREMOR ◯ WEIGHT GAIN ◯ WEIGHT LOSS

Is there anything else you would like us to know?

OHSU