The GW Medical Faculty Associates

Date: _____

Headache Questionnaire

ALL HEADACHE PATIENTS

We would appreciate your cooperation in filling out this form. In our evaluation of headache, your history is typically our most valuable tool for diagnosis and subsequent treatment. If you have any questions regarding this form, please ask.

Identification

Name: _____ Age: _____ Sex: _____

How were you referred to the Headache Clinic? (name, address, fax and phone of referring physician, if known; if not referred by a physician, write "self").

_____

_____

Headache History

How old were you when you first began to have headaches bad enough to interfere with your normal daily activities?

_____

_____

Has there been any recent change in your headaches? ☐ Yes ☐ No

If you answered yes, when did this occur? _____

If you answered yes, please specify what type of change: _____

_____

How many days within the last 30 days were you headache-free or nearly so? _____

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

How many headache days have you had in the past 30 days? _____

How many of these days were headaches severe? _____

Do you have daily headaches? ☐ Yes ☐ No

If yes, roughly how long have you had a headache every day? _____

How long do your worst headache attacks last? *(check box)*

☐ 0-1 hr ☐ >1-3 hr ☐ 4-12 hr ☐ >12-24 hr ☐ >24-48 hr ☐ > 48-72 hr ☐ > 72 hr

☐ constant ☐ too variable ☐ unknown

With your most severe headaches, does physical activity worsen the pain? ☐ Yes ☐ No

Is your headache pain ever throbbing? ☐ Yes ☐ No

Is your headache ever localized to one side of the head? ☐ Yes ☐ No

If yes, is your headache always on the same side? ☐ Yes ☐ No

If yes, which side? ☐ Right ☐ Left

Do your headaches often seem to begin in your neck or skull base? ☐ Yes ☐ No

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

- ☐ Eye tearing
- ☐ Nasal congestion/runny nose
- ☐ Eyelid drooping
- ☐ White part of eye becoming red
- ☐ Nausea
- ☐ Vomiting
- ☐ Visual changes *(visual distortion, "flash cubes", "zig-zags", "blind spots", "sparkles", etc).*
  please describe: _____
- ☐ Numbness or tingling in the face, arm or leg
  please describe: _____
- ☐ Inability to tolerate bright light (photophobia)
- ☐ Sensitivity to sound (phonophobia)
- ☐ Sensitivity to smell
- ☐ Sensitivity to motion

Do you know of anything that triggers your headaches? ☐ Yes ☐ No
If yes, please list triggers: _____

How many Emergency Room or Urgent Care visits due to headache have you had within the past 12 months? _____

Please answer the following questions about ALL of the headaches you have had over the past 3 months:

- ☐ On how many days in the last 3 months did you miss work or school because of your headaches?
- ☐ How many days in the last 3 months was your work or school productivity reduced by half or more because of your headaches? (Do not include days you counted in previous question where you missed work or school)
- ☐ On how many days in the last 3 months did you not do household work (home repairs and maintenance, shopping, caring for children and relative, housework) because of your headaches?
- ☐ How many days in the last 3 months was your household work productivity reduced by half or more because of you headaches? (Do not include days you counted in previous question where you did not do household work)
- ☐ On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches?

_____ **Total (Questions 1-5)**

Medical History

Please check the following items that pertain to you and your medical history:

- ☐ Hypertension (high blood pressure)
- ☐ Heart Disease *(please discribe:* _____ *)*
- ☐ Diabetes
- ☐ Significant head injury
  If yes, was it within the past 6 months? ☐ *Yes* ☐ *No*
  If no, please describe: _____
- ☐ Kidney stones
- ☐ Sleep apnea
- ☐ Panic attacks
- ☐ Drug allergies: *please list drug(s) and reaction(s):* _____
- ☐ Treated for depression in the past with counseling, medication or both

Please list any other significant medical conditions or psychiatric problems not listed on the previous page for which you are under the care of another physician.

_____

_____

If you are a female and potentially able to become pregnant, are you practicing birth control? ☐ Yes ☐ No

If yes, what method? _____

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

If yes, what type (CT, MRI, Both or Unknown): _____

Where and when was the most recent scan performed? _____

Family History

Has anyone in your family had a significant problem with headaches or been diagnosed as having migraine or "sick" headaches?

☐ Yes ☐ No *If yes, who?* _____

Social History

What is your occupation? _____

Are you: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Do you have children? ☐ Yes ☐ No

If yes, please list ages and gender: _____

Please check the appropriate boxes:

- ☐ Never smoked tobacco
- ☐ Current smoker (# of cigarettes per day _____ , # of years _____)
- ☐ Former smoker (quit date: _____ , # of years _____)
- ☐ Never consumed alcoholic beverages
- ☐ Currently consume alcoholic beverages (# of drinks per week _____)
- ☐ Past history of drinking heavily (quit date: _____ , # of years _____)
- ☐ Never used recreational drugs (marijuana, cocaine, heroin, etc)
- ☐ Currently use recreational drugs (which drug(s)?: _____
- ☐ Past history of using recreational drugs (quit date: _____ , which drug(s): _____)

Review of Systems

Are you currently having difficulties with your sleeping (insomnia, early morning awaking, " always sleepy", etc)? ☐ Yes ☐ No

If yes, please describe: _____

_____

Do you snore? ☐ Yes ☐ No

Have you experienced any weight changes? ☐ Yes ☐ No

If yes, please list how many pounds you: ☐ gained _____ lbs ☐ lost _____ lbs

Are you currently depressed? ☐ Yes ☐ No

If yes, is your depression ☐ mild ☐ moderate ☐ severe?

Are you chronically anxious? ☐ Yes ☐ No

Research

Our Headache Center offers participation in multiple research studies aimed at understanding headache disorders and/or their treatments. Some of these studies pay patients to compensate for their time participating in the study. If eligible, are you interested in potentially participating in research now or in the future? ☐ Yes ☐ No ☐ Maybe

Other

Please note below anything else you think is important for your doctor to know.

_____

_____

Headache Preventative Medications, Past and/or Present

Drug Name	Maximum dose achieved	How long taken?	Effective? Y / N	Side effects, if any.	Why stopped?
Topiramate/short-acting (Topamax)					
Topiramate/long-acting (Trokendi XR, Qudexy XR)					
Divalproex (Depakote)					
Amitriptyline (Elavil)					
Nortriptyline (Pamelor)					
Propranolol (Inderal)					
Zonisamide (Zonegran)					
Verapamil					
Occipital nerve blocks					
Botox injections					
Erenumab (Aimovig)					
Fremanezumab (Ajovy)					
Galcanezumab (Emgality)					
Other: _____					

Medications for Treatment of Acute Headache, Past and/or Present

Drug Name	Maximum dose achieved	How long taken?	Effective? Y / N	Side effects, if any.	Why stopped?
Oral sumatriptan (Imitrex)					
Injectable sumatriptan (Imitrex, Zembrace)					
Intranasal sumatriptan (Imitrex, Onzetra, Tosymra)					
Rizatriptan (Maxalt)					
Oral zolmitriptan (Zomig)					
Intranasal zolmitriptan (Zomig)					
Eletriptan (Relpax)					
Almotriptan (Axert)					
Frovatriptan (Frova)					
Naratriptan (Amerge)					
Treximet					
DHE nasal spray					
Injectable DHE					
Indomethacin					
Naproxen sodium					
Oral steroid (eg, prednisone)					
Cambia					
Ubrogepant (Ubrelvy)					
Other: _____					
Other: _____					

FOR HEADACHE PROVIDER ONLY

Suspected diagnosis (diagnoses):