



Headache History & Profile Questionnaire

Name: _____ Date: _____

On what part of the head do your headaches start?

- (R) side (L) side Either Side Both Sides
 Back On Top Temples Behind/Around Eyes
 Forehead Face Neck Other

How long ago did your current headache start? Days Weeks Months Years

How old were you when your headaches started? _____

How long do your headaches usually last? Minutes Hours Days Constant

How often do your headaches occur? x/Day x/Week x/Month x/Year Constant

Is the headache getting More Severe More Frequent Both

After the headache starts, does it usually Stay in one place Move around

Please explain: _____

How would you describe the pain? Throbbing Pulsating Pressing Squeezing
 Stabbing Sharp Dull/Nagging Other

Describe the degree of pain when your headaches **start** Slight 1 2 3 4 5 6 7 8 9 10 Worst Imaginable

Describe the degree of pain with **most** of your headaches Slight 1 2 3 4 5 6 7 8 9 10 Worst Imaginable

Describe the degree of pain with your **worst** headaches Slight 1 2 3 4 5 6 7 8 9 10 Worst Imaginable

Do your headaches interfere or prevent normal activities? Work, Social, etc... Yes No

Has your productivity at work or school been affected by your headaches? Yes No

In the **last month** have your headaches caused you to miss: Leisure/Social/Work/School? Yes No

In the **last 6 months** have your headaches caused you to miss: Leisure/Social/Work/School? Yes No

Do any blood relatives have severe headaches? Yes No If "Yes" who? _____

Do you have a history of head or neck injury? Yes No

If "Yes" did it involve loss of consciousness? Yes No

Which of the following makes the headache better?

- Rest Activity Darkness Quiet Hot Compress Cold Compress
 Pregnancy Menopause Scalp/Temple Pressure



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Lifestyle:

Do you exercise regularly? Yes No If yes, how often? _____

Do you frequently skip meals? Yes No

How much caffeine do you eat/drink in a day? (coffee, tea, soda, chocolate) _____

Do you smoke cigarettes? Yes No If yes, how many per day//# years ____/____

Do you drink alcohol? Yes No If yes, how many oz per day? _____

Do you drink coffee/tea? Yes No If yes, how many cups per day? _____

Do you have problems sleeping? Yes No

Do your headaches wake you up? Yes No

Do you wake feeling rested? Yes No

Are you or have you been Depressed Anxious

Associated Headache Symptoms:

Are any of the following symptoms associated with your headaches? **Please mark (B) before (D) during (A) after**

Spots before eyes/type Blindness (R/L) Blurring (R/L) Eyelid droop (R/L)

Can see only ½ of objects Tearing Double Vision Eye redness (R/L)

Puffy Eyes (R/L) Light sensitivity Noise sensitivity Odor sensitivity

Stuffy nose Runny nose

Abdominal

Nausea Vomiting Stomach cramps
 Hunger Loss of appetite Diarrhea

Face/Scalp

Pale Redness Sweating Tender
 Pain while chewing Puffy Decreased jaw opening



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State of mind

Depression Fatigue Anxiety
 Irritability Difficulty concentrating Difficulty talking (finding words)
 Difficulty understanding Fainting (feeling like or actually) Dizzy

Hands and or feet

Cold Pale Sweaty Mottled

Weakness (W) Numbness (N) Both (B)

Face (R/L) Arms (R/L) Legs (R/L) Arm & Leg (R/L)

Indicate if any of the following factors have:

(+) brought on a trigger or (++) worsen your headache

Sleep too much/too little Sexual Activity Chocolate Medication (list)
 Emotional stress Missed meals Citrus fruit Menstrual Periods
 Depression/Anxiety Change in weather Cheeses Pregnancy
 Physical Activity Seasons MSG Menopause
 Erect position Alcohol Other foods (list) Oral Contraceptives
 Bending over Processed meats Straining Coughing