SouthernCalifornia
Movement Disorder Specialists

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HEADACHE QUESTIONNAIRE

Patient Name: ____________________________________ Date: __________________________

1. **How frequent are your headaches?** _______x Daily ______x Week ______ x per month

2. **What year did your headaches/migraines begin?** ____

3. **Have your headaches gotten worse?** YES NO **If So, how long?** ___weeks ___months __years

4. **Where are your headaches located? (circle)** Both sides One side Entire Head Frontal Back of head Temples Top of head

5. **What time of the day do they occur?** Morning Afternoon Night

6. **What is the range of severity of your headaches (from least to greatest) on a scale of 1-10 (ten being the worst)?** ____

7. **What makes your headache better or worse?**
____
____

8. **What is the duration of your headaches?** ______ hours _________days

9. **Do you wake up with a headache?** Yes No

10. **Do they keep you up or wake you up in the middle of the night?** Wake up Keep up Both

11. **What other symptoms accompany the headaches?** Dizziness Nausea Vomiting Neck pain Numbness/tingling Weakness Passing out

12. **Are the senses (eyesight, hearing or touch) affected?** Visual loss Sensitivity to light Changes in smell Changes in taste Spots or wavy lines Blurry vision

13. **Is there a history of headaches in your family? If so, who?**
____

14. **What is the character of the pain?** Dull stabbing throbbing aching piercing

15. **Women: do they occur during your menstrual cycle? How long/often before, during, after?**

____
____

16. **Where are you when the headaches generally occur more often?** Home office shopping don't notice a difference

17. **Are you currently taking any medications, prescribed or over the counter? If so, what?**

____
____
____

18. **What many hours a night do you sleep?** ____

19. **Do the headaches ever occur during sexual activity?** Yes No

20. **Do certain foods or skipping meals affect your headache? If so, what foods?**

____
____
____
____

21. **Are your headaches affected by the weather?** Yes No

22. **Have you ever been treated/evaluated for these headaches? If so, what tests or procedures have you had? Please include name of facility?**

____
____
____
____

23. **How many times in the past year have you gone to the ER or hospital for your headaches?** _____

24. **How many days of work do you miss a month on average due to headaches?** _________________

25. **Have you had allergy testing?** YES NO **If so, what were the results?**

____
____

26. **List *ALL* over the counter and prescribed medications you have tried, along with dosage/strength**

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____