Patient Name _____ Date of Birth _____

Today's Date _____

Headache Questionnaire

Directions: Please answer yes or no to any questions...

	YES	NO
1. Did this same headache ever occur before?		
2. Do you have more than one type of headache?		
3. Do your headaches usually occur during daytime hours?		
4. Does your mother, father, siblings, children or any blood relative have similar headaches? (answer NA if adopted)		
5. Do you have any changes in vision (flashing lights, blurred vision, or spots) before or during a headache?		
6. Does your headache pain throb or pound?		
7. Do your headaches occur during weekends and holidays?		
8. Do alcoholic drinks cause or aggravate your headaches?		
9. Does chocolate, cheese, milk, nuts, Chinese food, or any food cause or worsen your headache?		
10. Have you noticed any paralysis, muscle weakness, numbness, swallowing problems or speech changes during your headaches?		
11. Would you describe your headache as moderate to severe in intensity?		
12. Does your headache ever require you to lie down?		
13. Do you prefer a dark, quiet room when you have a headache?		
14. Do you ever miss work (or school) because of headache?		
15. Do you see zig zag lines before a headache?		
16. Does your headache last between 1 to 3 days?		
17. Is your headache unresponsive to plain aspirin or Tylenol?		
18. Do bright lights or sunshine cause your bad headaches?		
19. Does a change in barometric pressure, or storms, ever trigger your headache?		
20. Does a change in your sleep schedule trigger your headaches?		
21. Does your headache pain feel as if your heart is beating in your head?		
22. Did your headaches begin in adolescence or early adulthood?		
23. Do you ever feel tired prior to a headache starting?		
24. Do you ever have excessive thirst/hunger prior to a headache?		
25. Do odors such as perfumes or gasoline fumes ever trigger a headache?		
26. Do you feel drained or "worn-out" the day after a headache?		

	YES	NO
27. Did you ever suffer from motion sickness as a child?		
28. Do you lose your appetite with a headache?		
29. Do you ever feel lightheaded or off-balance with a headache?		
30. Do you ever experience difficulty thinking or speaking clearly with a headache?		
31. Do you ever have diarrhea after a headache?		
32. Does constipation ever seem to trigger your headaches?		
33. Is it difficult to read during a headache?		
34. Will watching TV aggravate a headache?		
35. Is your headache pain dull and steady, like an intense constant pressure?		
36. Do you usually have more than 5 headaches per week?		
37. Do you headaches usually occur during the night?		
38. Do you have watering of the eye on the affected side of the headache?		
39. Do you get multiple headaches, which wake you, during the night?		
40. Would you describe your headache pain as a red hot poker in one eye?		
41. Would you describe your headaches as a squeezing or vise-like sensation?		
42. Do you always have a headache (daily headache)?		
43. Does coughing or sneezing ever start a headache?		
44. Do you tend to pace the floors with a headache?		
45. Do you get several very intense headaches daily, each lasting less than 5 minutes?		
46. Are your headaches so excruciating that you have considered suicide?		
47. Can you have 6-12 month periods when you experience NO headaches?		
48. Is your headache less bothersome if you keep active at work or play?		
49. Do you neck or shoulder muscles feel tight and painful during the headache?		
50. Do you have frequent muscle and joint pain?		
51. Have you been feeling down or depressed?		
52. Have you noticed a decrease in your sexual desire or drive?		
53. Do you often feel moody or easily irritated?		
54. Have you noticed a general change/distortion in your perception of taste?		