NAME_____ DOB_____

HEADACHE QUESTIONNAIRE

At what age did you have your first headache? _____
What year did your current headaches begin? _____
When was your last headache? _____
Are you ever free of pain completely? _____Yes _____No
Do you have more than one type of headaches? _____Yes _____No
If yes, describe them separately: _____

How many headaches (any type) do you have each month? _____ how long do they last? ___
How would you describe the pain of your most serious headaches (circle as many as apply):
throbbing pulsating dull aching sharp stabbing hot vise-like burning sickening blinding unbearable electric-like pressure

When you have a headache (and possibly after), do your scalp and face become sensitive to touch and do you avoid putting on glasses, jewelry or combing your hair? _____Yes _____No

Are your headaches brought on by:
exercise stress relaxation after stress change in weather alcohol noise your periods/hormonal changes bright light/glare odors smoke dehydration lack of sleep too much sleep hunger food additives certain foods allergies

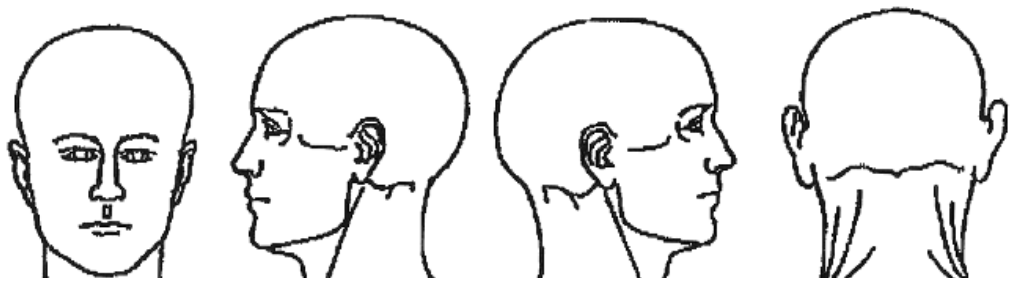
Do your headaches occur on any particular day(s) of the week or time of day: _____
Do you have any warning signs before the start of a headache: _____Yes _____ No
Describe: _____

Circle any of the following symptoms you have with your headaches:

neck pain nausea vomiting light sensitivity dizziness fever numbness noise sensitivity weakness confusion difficulty speaking nasal congestion tearing eyelid drooping worsening of pain with movement

Other: _____

Please indicate with X's where you experience pain:



HEADACHE QUESTIONNAIRE (cont.)

Have you ever been treated for headaches? _____Yes _____No
What kind of headaches were you told you have: _____
Have you had any tests done to diagnose your headaches? ___Yes _____No
Describe: _____

Which of the following medicines have you tried for headaches (of any kind)? Circle all that apply:

Anaprox	Codeine	Imitrex/Sumatriptan	Percogesic
Aspirin	Darvon/Darvocet	Inderal/Propanolol	Phrenilin Forte
Anacin	Dexamethasone/Decadron	Indocin/Indomethacin	Relpax
Advil/Ibuprofen	Decongestants	Lamictal	Robaxin
Aleve/Naproxen	DHE-45	Lidocaine	Stadol
Amerge	Demerol	Lithium	Talwin
Axert	Depakote	Lyrica	
Topamax/Topiramate			
Axotal	Desyrel/Trazodone	Maxalt	Tylenol
Amitriptyline/Elavil	Dilantin/Phenytoin	Migralex	
Ultram/Tramadol			
Atacand	Effexor	Migranal	Ultracet
Benicar	Esgic	Motrin/Ibuprofen	Valium
Beta-blockers	Ergostat	Neurontin/gabapentin	
Vivactyl/Protriptyline			
Botox	Excedrin	Naprosyn/Anaprox	Wigraine
Bufferin	Fioricet/butalbital	Panadol	Xanax
Cafergot	Fiorinal/butibital	Pamelor/nortriptyline	Zanaflex
Calan/verapamil	Flexeril	Percocet/oxycodone	Zomig
Cymbalta	Frova	Percodan	Zonegran

Other: _____

Please STAR (*) those which helped, even for a while.

Have you tried any of the following alternative treatments (circle all that apply):
Biofeedback Acupuncture Chiropractic Physical Therapy
Supplements: Feverfew B12 Magnesium MigreLief CoQ10 Butterbur

Other: _____

List all of your CURRENT headache medications and dosing (over the counter and prescribed):

List all other medications you are taking and the reason (prescribed, over the counter, vitamins, herbs):
-

Please list all allergies, if any: _____

Migraine Disability Assessment

Instructions: Please answer the following questions about all of your headaches over the past 3 months. Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months.

1. On how many days in the last 3 months did you miss work or school because of your headaches? (If you do not attend work or school, enter zero in the space to the right). ☐

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headache? (Do not include days you counted in question 1, enter zero if you do not attend work/school) ☐

3. On how many days in the last 3 months did you not do household work because of your headaches? ☐

4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school. If you do not attend work or school, enter zero at right). ☐

5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches? ☐

A. On how many days in the last 3 months did you have a headache? (If headache lasted more than 1 day, count each day) ☐

B. On a scale of 0-10, on average, how painful were these headaches? (Where 0=no pain at all, and 10=pain which is as bad as it can be). ☐

Add the total number of days from questions 1 to 5 (ignore A & B). ☐

Have you been bothered a lot in the last month by feeling sad, down or depressed _____ Yes _____ No
Have you been bothered a lot in the last month a loss of interest/pleasure in daily activities? ___ Yes___No

SLEEP DISORDERS ASSESSMENT

1. Do you snore? _____ Yes _____ No
2. Do you, or have you been told, that you stop breathing while you are sleeping? _____ Yes _____ No
3. Do you wake suddenly or frequently during the night? _____ Yes _____ No
4. Do you ever wake up gasping for air? _____ Yes _____ No
5. Do you wake up in the morning feeling tired? _____ Yes _____ No
6. Do you wake up in the morning with a headache? _____ Yes _____ No
7. Do you nap during the day? _____ Yes _____ No If yes, how long do you nap for? _____
8. How likely are you to fall asleep while: watching TV? _____very likely _____ not likely
9. How likely are you to fall asleep while driving? _____ very likely _____ not likely
10. Have you ever been diagnosed with any sleep disorder? _____ Yes _____ No Describe: _____
11. Do your legs feel restless at night? _____ Yes _____ No
12. Do you currently use a CPAP or BIPAP machine? _____ Yes _____ No