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

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

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

5. **What makes your headache better or worse?**
_____
_____

6. **What is the duration of your headaches?** _____ hours _____ days

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

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

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

10. **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

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

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12. **What is the character of the pain?** Dull Stabbing Throbbing Aching Piercing

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

_____

_____

14. **Where are you when the headaches generally occur more often?**
Home Office Shopping Don't notice a difference

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

_____

_____

_____

16. **What many hours a night do you sleep?**

_____

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

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

_____

_____

_____

_____

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

20. **Have you ever been treated/evaluated for these headaches? If so, what tests or procedures have you had?**

_____

_____

_____

_____

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

_____

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

_____