MEDICAL FACULTY ASSOCIATES

THE GEORGE WASHINGTON UNIVERSITY

Headache Questionnaire

EPISODES

1. How old were you when you first had these headaches? Age:_____
2. Did you have these headaches in the past? ❒ Yes ❒ No

3. When was your last headache? _____

	(TIMES PER) Day	Week	Month
4. On average, how often do you have these headaches? →			
5. What about when your headaches were at their worst?			

	(TIMES PER) Minutes	Hours	Days
6. On average, how long does your headache last? →			
7. What about when your headaches were at their worst?			

8. Does your headache tend to come on as attacks (suddenly)?
❒ No ❒ Sometimes ❒ Usually ❒ Always

9. How would you describe the quality of pain?
❒ throbbing, pulsating, pounding ❒ stabbing ❒ pressing/tightening
❒ dull ache ❒ squeezing ❒ Other _____

10. Does the pain usually occur on one side of your head? ❒ Yes ❒ No
Which side? ❒ Right ❒ Left ❒ Both ❒ Don't Know

11. ON THE DIAGRAM BELOW, PLEASE CIRCLE THE LOCATION OF PAIN.

FRONT BACK LEFT SIDE RIGHT SIDE

LABEL

12. Does the pain usually change with any of the following?
- Walking or walking upstairs ❒ No Change ❒ Worse ❒ Better ❒ Never Tried ❒ Don't Know
- Jumping or playing ❒ No Change ❒ Worse ❒ Better ❒ Never Tried ❒ Don't Know
- Coughing, sneezing ❒ No Change ❒ Worse ❒ Better ❒ Never Tried ❒ Don't Know
- Sleeping ❒ No Change ❒ Worse ❒ Better ❒ Never Tried ❒ Don't Know
- After sleep ❒ No Change ❒ Worse ❒ Better ❒ Never Tried ❒ Don't Know

13. How would you characterize the intensity of the pain you experience?
❒ Mild ❒ Moderate ❒ Severe ❒ Extreme

TRIGGERS

14. Have you noticed your Headaches occurring after ingesting any foods such as…
❒ Cheese ❒ Chocolate ❒ Nuts ❒ Other _____
❒ Alcohol (any type) _____

VISUAL CHANGES

15. Do you ever have any changes in your vision with your headaches? ❒ Yes ❒ No

16. Do you ever have these changes in your vision without headaches? ❒ Yes ❒ No

17. Do you experience:
- Flickering or flashing lights, Showers of light? ❒ Never ❒ Sometimes ❒ Often ❒ Not Sure
- Blurred vision? ❒ Never ❒ Sometimes ❒ Often ❒ Not Sure
- Spots before eyes? ❒ Never ❒ Sometimes ❒ Often ❒ Not Sure
- Zigzag lines, Geometric shapes, Stars? ❒ Never ❒ Sometimes ❒ Often ❒ Not Sure

18. How long do these changes in your vision usually last? _____

19. How much time generally elapse between the beginning of the earliest visual change and the onset of the headache?

SECONDS	MINUTES	HOURS	DAYS

NEUROLOGICAL CHANGES

20. Are your headaches accompanied by any problems?
- speech? ❒ Never ❒ Sometimes ❒ Often ❒ Not Sure
- thinking? ❒ Never ❒ Sometimes ❒ Often ❒ Not Sure
- difficult word finding? ❒ Never ❒ Sometimes ❒ Often ❒ Not Sure
- sensations (numbness, weakness, tingling)? ❒ Never ❒ Sometimes ❒ Often ❒ Not Sure

LABEL

21. How much time generally elapse between the beginning of the earliest (neurological change) and the onset of the headache?

SECONDS	MINUTES	HOURS	DAYS

22. Are you usually able to tell when a headache is about to occur? ❒ Yes ❒ No

23. How are you able to tell? (check all that apply)

❒ Changes in vision
❒ Changes in speech
❒ Difficulty thinking, concentrating
❒ Numbness, tingling, Weakness
❒ Changes in energy, malaise
❒ Changes in mood
❒ Changes in appetite
❒ Feeling ill, nauseated
❒ Sleep disturbances
❒ Other_____

24. Do you ever feel nauseated, sick to your stomach, or have diarrhea or other digestive problems with your headaches? ❒ Yes ❒ No

25. Does light usually bother you during a headache? ❒ Yes ❒ No

26. Does noise (i.e. radio, TV, voices, moving a chair across the floor) usually bother you during a headache? ❒ Yes ❒ No

27. Do particular odors (i.e. perfume, food, gasoline, smoke) bother you during a headache? ❒ Yes ❒ No

WOMEN ONLY:

28. Are these headaches ever associated with your menstrual cycle? ❒ Yes ❒ No
29. When do your headaches begin, with respect to your period? ❒ Yes ❒ No

FAMILY HISTORY

30. Does anyone in your family suffer from Headaches? ❒ Yes ❒ No
Who? _____

31. Please provide any family history pertaining to your headaches.

MEDICATION HISTORY

32. Do you currently take any prescribed medicines to treat your headache? ❒ Yes ❒ No

33. Do you currently take non-prescribed or over-the-counter medicines for headaches? ❒ Yes ❒ No

_____
_____
_____
_____
_____
_____

LABEL

34. Please tell me which medications you have tried.

NAME OF DRUG	**HELPED?**
	❒ Yes ❒ No
	❒ Yes ❒ No
	❒ Yes ❒ No
	❒ Yes ❒ No
	❒ Yes ❒ No
	❒ Yes ❒ No
	❒ Yes ❒ No

Please provide any additional information pertaining to your headaches.

LABEL