Triangle Neurology and Sleep Lab, PA
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Headache Questionnaire – Page 1

Name : _____ Date : _____

1. How long your headaches have been present?

2. Description of pain:

---- Right or left sided
---- Temple region
---- Frontal region
---- Base of skull with neck pain
---- Top of head

3. Quality of pain

---- Throbbing
---- Stabbing
---- Aching
---- Pressure

4. Intensity of pain on a scale of 1-10 (circle one)

1 2 3 4 5 6 7 8 9 10

5. Average duration of pain

---- Minutes
---- Hours
---- Days

6. Frequency of headaches

---- Hourly
---- Daily
---- Weekly

7. Any associated symptoms

---- Nausea
---- Vomiting
---- Changes in vision such as: vision loss, blurry vision, double vision
---- Dizziness
---- Fainting spells

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Headache Questionnaire – Page 2

8. What makes your headaches easier to tolerate?

9. What makes you headaches worse?

10. What is your average caffeine intake (coffee, tea, and/or soda) daily?

11. Are your headaches related to your menstrual cycle?

12. What medications do you take to stop your headaches, including over-the-counter medications?

---- Tylenol
---- Advil
---- Motrin
---- Exedrin Migraine
---- BC Powder

13. What medications have you tried for preventive treatment of headaches?

---- Inderal/propranolol
---- Topamax
---- VerapamilElavil/amitrypyline
---- SSRI's like Prozac, Effexor, Zoloft, Paxil, Celexa, Lexapro
---- Wellbutrin
---- Neurontin
---- Keppra
---- Tegretal
---- Muscle Relaxants

14. What triptans have you tried, any side effects?

---- Maxalt MLT
---- Migranal
---- Amerge
---- Frova
---- Imitrex
---- Zoming

15. Is your sleep pattern affected by your headaches? Please describe.

16. Do you have a family history of headaches?