

**Upstate Neurology Consultants, LLP
Headache Questionnaire**

Name: _____ Date of birth: _____

1. How long have you had headaches?
2. How often do your headaches occur? __Daily __Weekly _____Days a week ___Days a month
3. How long do your headaches usually last?
4. How long does it take from the onset of the headache (the first clear warning that it is going to occur) to its maximum intensity?
5. Are there any triggers for your headaches such as foods (chocolate, nuts, peanut butter, smells, tobacco smoke, red wine, MSG, cured meats, nutrasweet), activities (exercise or exertion), menstrual cycle, lack of sleep, missed meals, heat or bright light?
6. Are your headaches: A) Steady B) Squeezing C) Throbbing D) Sharp E) Stabbing
7. Are your headaches in any specific area of your head? A) One-sided B) Back of Head C) Band-Like D) Behind the eyes E) Forehead F) Other
8. Do you have any warning symptoms before your headache: A) Flashing lights B) Numbness or weakness of part of the body? C) Dizziness D) Difficulty speaking E) Visual loss F) Other
9. Are there other symptoms that accompany your headaches? A) Nausea or vomiting B) Sensitivity to light C) Sensitivity to sound D) Passing out E) Loss of or blurring of vision
10. Do your headaches keep you awake? Do your headaches wake you up? Get worse with activity?
11. Does anything help your headache?
12. Does anyone else in your family have headache? If so, who?
13. Have you ever had a CT or MRI of your head?
14. Have you ever taken any of these medications?

	Now	Ever	Any Help?	Side Effects
Amitriptyline/Elavil				
Nortriptyline/Pamelor				
Inderal/Propranolol				
Depakote				
Verapamil/Cardizem				
Imitrex/Maxalt/Zomig				
Ergotamine				
DHE-45/Migranal				
Fioricet/Fiorinal/Butalbital				
Sansert				
Topamax				
Amerge				
Tylenol/Ibuprofen/Alleve				

15. How often do you take Tylenol, aspirin, Excedrin or other over-the-counter preparations?
16. How much caffeinated coffee/tea/soda do you drink?