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HEADACHE MEDICINE

NEW PATIENT QUESTIONAIRE

Name _____

Date _____

Age your headache began _____ (or how long ago did they start? _____)

Do you have more than one type of headache? ☐ Yes ☐ No

If yes, answer the following questions about *your most disabling headache type.*

Do you get any of the following symptoms hours to days before the headache starts?

☐ Food cravings or hunger ☐ Unexplained mood change ☐ Uncontrollable yawning

☐ Excessive thirst ☐ Excessive urination ☐ Drowsiness ☐ Euphoria ☐ Other _____

What part of your head and neck hurt? _____

What does it feel like (aching, throbbing, etc.)? _____

How often do your headaches occur? _____

How long do they last? On average _____ Longest _____ Shortest _____

How severe is your pain? Mild _____ Moderate _____ Severe _____

Do you have any warning before the pain starts (aura)? ☐ Yes ☐ No

If yes, describe _____

Do you have any of the following **with your headaches** (check all that apply):

☐ Nausea or inability to eat ☐ Worsening with activity (walking, climbing stairs)

☐ Vomiting ☐ Numbness or tingling ☐ Ringing in ears

☐Sensitivity to light ☐ Weakness on one side of the body/ face

☐Sensitivity to noise ☐ Difficulty speaking ☐ Imbalance

☐ Sensitivity to odors ☐ Confusion ☐ Spinning dizziness

☐ Diarrhea ☐ Tearing from the eye(s) ☐ Double vision

☐ Stuffy nose ☐ Bloodshot eye(s) ☐ Droopy eyelid

☐ Runny nose ☐ Restlessness ☐ Other _____

Do your headaches ever awaken you from sleep? ☐ Yes ☐No *If yes, at what time?* _____

Do you have to/prefer to lie down with your headaches? ☐ Yes ☐ No

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Do any of the following worsen your headaches?

☐ Coughing ☐ Sneezing ☐ Laughing ☐ Lifting ☐ Straining or bending down

☐ Sexual activity

Are your headaches better at any particular time of the day? _____

Are your headaches worse at any particular time of the day? _____

Is your headache severity affected by lying down, sitting or standing? _____

Have you identified anything that triggered your headaches? ☐ Yes ☐ No

If yes, list: _____

_____

Describe: _____

Have your headaches cause problems in any of the following areas of your life?

☐ Job ☐ Housework ☐ School ☐ Home life ☐ Relationships ☐ Social life ☐ Legal

Women: Do any of the following affect your headaches?

☐ Birth control pill ☐ Pregnant ☐ Menopause ☐ Hormone replacement therapy

Explanation: _____

On average, how many days monthly are you *headache-free?* _____

Have you had a brain CT or MRI? ☐ Yes ☐ No (*If yes,* **bring film or CD with you)**

How much caffeine do you consume? _____

In what form ☐ Coffee ☐ Tea ☐ Soda ☐ Chocolate ☐ Excedrin or medication

Do you use or consume foods or beverages containing Nutrasweet/Equal/aspartame? ☐ Yes ☐ No

How much sleep do you get every night on average? _____ hours

Have you ever been told that you stop breathing or gasp during sleep? ☐ Yes ☐ No

Have you ever been diagnosed with sleep apnea? ☐ Yes ☐ No

Have you ever had a concussion? ☐ Yes ☐ No Details: _____

Have you ever been physically, sexually or emotionally abused? ☐ Yes ☐ No

Are you currently in an abusive relationship? ☐ Yes ☐ No

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Do any family members have migraines or "sick headaches"? ☐ Yes ☐ No

If so, whom? _____

Do any family members have cluster headaches? ☐ Yes ☐ No

If so, whom? _____

What medications have you tried for *acute (symptomatic) treatment* of headache (you took it when you got a headache)? Include medications for nausea and over the counter. If you can't remember, try and get your pharmacy records and bring them with you.

Medication	Dose (mg)	How long ago/when?	Was it effective?	Side effects

What medications have you tried for *prevention of headache* (take it daily to prevent headaches)?

Medication	Highest dose taken (mg)	How long did you use it?	Was it effective?	Side effects

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ALLODYNIA QUESTIONNAIRE (ASC-12)					
How often do you experience increased pain or an unpleasant sensation on your skin during your most severe type of headache when you engage in each of the following?	**Does not apply to me**	**Never**	**Rarely**	**Less than half the time**	**Half of the time or more**
	Score: 0	Score: 0	Score: 0	Score: 1	Score: 2
Combing your hair					
Pulling your hair back (e.g. ponytail)					
Shaving your face					
Wearing eyeglasses					
Wearing contact lenses					
Wearing earrings					
Wearing a necklace					
Wearing tight clothing					
Taking a shower (when the water hits your face)					
Resting your face or head on a pillow					
Exposure to heat (e.g. cooking, washing your face with hot water)					
Exposure to cold (e.g. using an ice pack, washing your face with cold water)					
Total Score					
Sum of total scores					
For office use only: 0-2 none, 3-5 mild, 6-8 moderate, 9+ severe					

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MIDAS DISABILITY ASSESSMENT

This questionnaire is used to determine the level of pain and disability cause by your headaches and helps your doctor find the best treatment for you.

INSTRUCTIONS: Please answer the following questions about all your headaches **over the last 3 months.** Write your answer- **one number, not word or range** – in the box next to each question. Write zero if you did not do the activity in the past **3 months.** If you don't keep a headache calendar, provide your best estimate.

	DAYS (one number per box)
1. On how many days in the last 3 months did you miss work or school because of your headaches? (If you did not attend work or school enter zero in the box.)	
2. How many days in the last 3 months was your productivity at work or school 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 in the box*)	
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 counted in question 3, where you did not do household work*)	
5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches?	
TOTAL (Questions 1-5)	
A. On how many days in the last 3 months di you have a headache? (if headache lasted more than one 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.)	
For office use only: 0-5 Little to none, 6-10 mild, 11-20 moderate, 21+ severe	

STOP-BANG QUESTIONNAIRE FOR SLEEP APNEA RISK
Fill out starred (*)/ shaded items

		YES	NO
*S	Do you **snore** loudly (louder than talking or loud enough to be heard through closed doors)?		
*T	Do you often feel **tired**, fatigued, or sleepy during the daytime?		
*O	Has anyone ever **observed** you stop breathing during your sleep?		
*P	Do you have or are you being treated for high blood **pressure?**		
B	Is your **body mass index** greater than 35 kg/m^2		
*A	Are you older than 50 years?		
N	Does your **neck** measure more than 153/4 inches (40 cm) around?		
*G	Is your **gender** male?		
		Total Yes =	
For office use only: *High risk* of OSA: answering yes to 3 or more items *Low risk* of OSA: answering yes to less than 3 items			

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GENERAL ANXIETY DISORDER SCALE (GAD-7)				
Over the last 2 weeks, how often have you been bothered by the following problems	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
	Score: 0	Score: 1	Score: 2	Score: 3
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it's hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				
Total Score				
Sum of total scores				

If you checked off any problems, how difficult have these made it for you to do work, take care of things at home, or get along with people?	☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult
For office use only: 0-4 none, 5-9 mild, 10-14 moderate, 15+ severe	

Have you been diagnosed with:

	In the past	Currently have it
Fibromyalgia	_____	_____
Irritable bowel syndrome	_____	_____
Pelvic pain	_____	_____
Temporomandibular disorder (TMJ)	_____	_____
Painful bladder syndrome	_____	_____
Bipolar disorder (manic-depressive)	_____	_____

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PATIENT HEALTH QUESTIONNAIRE (PGQ-9)				
Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
	Score: 0	Score: 1	Score: 2	Score: 3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have et yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety and restless than you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
Sum of total scores				

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

For office use only: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20+ severe

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Note: if you have NEVER had any major stressful experience in the past, score 1 for all items.

If you had a **major stressful event,** what was it? _____

_____ When did it occur? _____

POST-TRAUMATIC STRESS DISORDER QUESTIONNAIRE (PCL-C)
Instructions to patient: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully, put an X in the box to indicate how much you have been bothered by that problem in the past month.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
B	1. Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience from the past?					
	2. Repeated, disturbing *dreams* of a stressful experience from the past?					
	3. Suddenly acting or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?					
	4. Feeling *very upset* when *something reminded you* of a stressful experience of the past?					
	5. Having physical reactions (e.g., heart pounding, trouble breathing, swearing) when something reminded you of a stressful even from the past?					
C	6. Avoid thinking about or talking about a stressful experience from the past or avoiding having feeling related to it?					
	7. Avoiding activities or situations because they remind you of a stressful experience from the past?					
	8. Trouble remembering the important parts of a stressful experience from the past?					
	9. Loss of interest in activities that you used to enjoy?					
	10. Feeling distant or cut off from others?					
	11. Feeling emotionally numb or being unable to have loving feelings for those close to you?					
	12. Feeling as if your future somehow will be cut short?					
D	13. Trouble falling or staying asleep?					
	14. Feeling irritable or having angry outbursts?					
	15. Having difficulty concentrating?					
	16. Being "superalert" or watchful or on guard?					
	17. Feeling jumpy or easily startled?					

For office use only: Supports DSM: 1B + 3C + 2D

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