New Patient Headache Questionnaire:

Please Answer ALL Questions!!!

1. When did you have your first headache? _____
2. Where does the pain start and where does it go? _____
3. Is one side more severe? _____ If so, which side? ☐R ☐L
4. Select the best description: ☐ache, ☐throb, ☐sharp, ☐stabbing, ☐tightness, ☐burning, ☐other(describe) _____
5. How many days per week do you have mild headaches? _____ days
6. How many days per week do you have severe headaches? _____ days
7. How many days per week are you completely headache free? _____ days
8. How many months/years have your headaches been at the current frequency? _____months _____years
9. On average, what is the duration of your headaches?
   ☐fewer than 4 hours ☐more than 4 hours
10. How severe is your mild headache, on a scale of 1-10 with 10 being the worst? ____/10
11. How bad are your severe headaches, on a scale of 1-10 with 10 being the worst? ____/10
12. **Select** all that apply during a headache: ☐nausea, ☐loss of appetite, ☐vomiting, ☐sensitivity to light, ☐sensitivity to sound, ☐sensitivity to smells, ☐spinning sensation, ☐lightheadedness, ☐weakness all over, ☐weakness on right, ☐weakness on left, ☐numbness/tingling all over, ☐numbness/tingling right, ☐numbness/tingling left, ☐trouble concentrating, ☐difficulty speaking, ☐watery eye right, ☐watery eye left, ☐runny nose, ☐droopy eyelid right, ☐droopy eyelid left

Nelson Neurology

13. Describe any visual changes with the headache:

    _____

14. Is the pain worse with sitting, standing or lying down? _____
15. Is the pain worse or better with activity? ☐Worse ☐Better
16. Do you wake up with the headache? ☐Yes ☐No ☐Sometimes
17. What triggers your headache?

    _____

18. Do you have neck pain with your headaches? ☐Yes ☐No
19. Have you had any CT scans or MRIs of you head or neck? ☐No ☐Yes - If so, when and where?

    _____

20. How many cups of caffeine do you drink daily? _____
21. Do you use artificial sweeteners? ☐Yes ☐No
22. Menstruating Individuals only - **Select** all that apply: Are your headaches worse with your: ☐menstrual period, ☐ovulation, ☐birth control pills, ☐pregnancy, or ☐menopause
23. Does anyone in your family have headaches? ☐Yes ☐No
24. Do you feel tired with reading or working on the computer? ☐Yes ☐No
25. Do you have headaches with reading or working on the computer? ☐Yes ☐No
26. Are you bothered by sunlight? ☐Yes ☐No
27. Are you bothered by headlights? ☐Yes ☐No
28. What over the counter medications do you currently take for your migraines or other pain? _____

    How many days per week do you take one or all of these? _____days
29. **Select** the preventive medications you have tried: ☐propranolol, ☐metoprolol, ☐verapamil, ☐amitriptyline, ☐nortriptyline, ☐valproic acid/depakote, ☐topiramate/Topiramate, ☐Botox, ☐venlafaxine/Effexor, ☐gabapentin/Neurontin, ☐pregabaline/Lyrica, ☐duloxetine/Cymbalta,

☐levetiracetam/Keppra, ☐erenumab/Aimovig, ☐fremanezumab/Ajovy, ☐galcanezumab/Emgality, ☐eptinezumab or ☐indomethacin/Indocin

30. What are you currently taking for preventive therapy?

_____

31. **Select** the symptomatic mediations you have tried: ☐naproxen/Aleve, ☐Excedrin, ☐sumatriptan/Imitrex, ☐eletriptan/Relpax, ☐almotriptan/Axert, ☐zolmitriptan/Zomig, ☐rizatriptan/Maxalt, ☐naratriptan/Amerge, ☐frovatriptan/Frova, ☐ubrogepant/Ubrelvy, ☐rimegepant/Nurtec, ☐lasmiditan/Reyvow, ☐DHE, ☐Fioricet,or Fiorinal.

32. What are you currently taking for symptomatic therapy?

_____

How many days per week do you take one or all of these? _____days

33. **Select** herbal or nutritional supplements you have tried: ☐magnesium, ☐Vit B2/riboflavin, ☐feverfew, ☐coenzyme Q10, ☐melatonin

34. Are you taking any herbal or nutritional supplements for headaches currently? ☐No ☐Yes - If so, what are you taking?

_____

35. How many hours do you sleep per night? _____hours

36. How many days per week do you exercise? _____days