Nor-Lea Hospital District

NAME:
DATE:

Part I Basic Questions

1. When you have headaches, how often is the pain severe?

Never Rarely Sometimes Very Often Always

2. How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

Never Rarely Sometimes Very Often Always

3. When you have a headache, how often do you wish you could lie down?

Never Rarely Sometimes Very Often Always

4. In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

Never Rarely Sometimes Very Often Always

5. In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

Never Rarely Sometimes Very Often Always

6. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

Never Rarely Sometimes Very Often Always

For Office Use Only (6,8,10,11,13) Score:

7. At what age do you remember your first significant headache? _____

8. When was the last day you were headache free? _____

9. When was the last time you had 6 headache-free days in a row? _____

10. How often do you have to go to the Emergency Room for headaches? _____

11. When your headaches first started, do you remember getting some relief by changing positions from sitting to lying? Yes or No

12. What other physicians have you seen for headaches/facial pain?
_____

13. Have you ever been admitted to the hospital for your headaches? _____

14. Have you tried chiropractic care or acupuncture for your headaches? Yes or No

15. What studies have you had for your headaches?
    a. MRI of head: Y/N Approximate date and place of procedure:_____
    b. CT scan of head: Y/N Approximate date and place of procedure:_____
    c. MRI of neck: Y/N Approximate date and place of procedure:_____
    d. Spinal Tap: Y/N Approximate date and place of procedure:_____

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16. Do you snore? Y or N
17. Do you clench or grind your teeth at night? Y or N
18. Do you snore? Y or N
19. Do you clench or grind your teeth at night? Y or N
20. Have you been diagnosed with TMJ disorder? Y or N
21. Does your neck hurt during the headaches? Y or N
22. Does your neck hurt when you don't have a headache? Y or N
23. Do you sleep well at night? Y or N

Part 2: Past Headache Treatment

Circle any of the medicines below that you tried before to stop headaches once they start:

Imitrex tablets	Imitrex injection	Imitrex nasal	Relpax	Zomig
Maxalt	Frova	Amerge	Migranal	Axert
Esgic	Fioricet	Fiorinal	Butalbital	Midrin
Tylenol	Advil (ibuprofen)	Aleve (naproxen)	Toradol	Hydrocodone
Caffergot	Indocin (indomethacin)	Ergotamine	Goody or BC powders	Excedrin

Other medicines used to stop headaches:

_____

Circle all of the medicines below you have used for <u>prevention</u> of headaches/facial pain:

Gabapentin (Neurontin)	Topamax	Amitriptyline (Elavil)	Nortriptyline (Pamelor)	Lamictal
Zonegran (zonisamide)	Lyrica	Depakote	Tegretol (carbamazepine)	Baclofen
Verapamil	Cyproheptadine	Prozac (fluoxetine)	Effexor (venlafaxine)	Naproxen (alleve)
Cymbalta	Keppra	Inderal (propranolol)	Toprol (metoprolol)	Atenolol

Other medicines used for headache prevention:

_____

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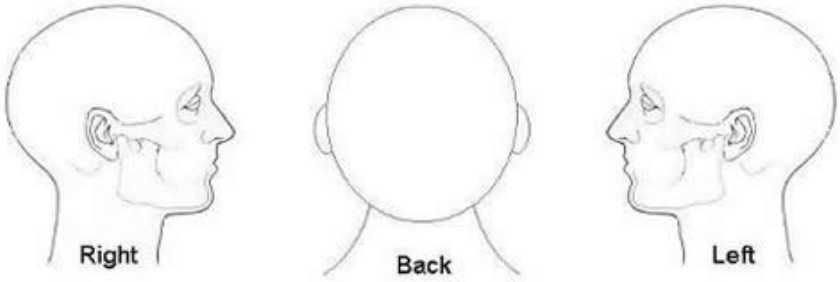
How many types of headaches do you have?_____ Fill out the information on this page and the following pages for each type of headache you have.

Headache #1

1. Mark the areas where your head hurts for this headache type:



2. Have you had this headache type for less than 3 months? Y or N
3. How would you describe the pain? (examples: throbbing, squeezing, dull, tightness, stabbing, shooting)

   _____

4. Do you have nausea with this headache? Y or N
5. Do you have sensitivity to light with this headache? Y or N
6. Do you have sensitivity to sound with this headache? Y or N
7. Do you have sensitivity to smell with this headache? Y or N
8. Do you have changes in your vision before or during this headache? Y or N
9. Has this headache changed recently? Y or N If so, How has it changed?_____
10. What time of day are these headaches the worst? _____
11. What medicines have helped this headache?

    _____

12. Circle any of the aggravating factors below:

Caffeine	Too Much Sleep	Too Little Sleep	Weather Changes	Stress
Aspartame	Chocolate	Strenuous activity	Monosodium glutamate (MSG)	Talking
Chewing	Menstrual period	Altered eating schedule	Alcohol Intake	Neck Movement

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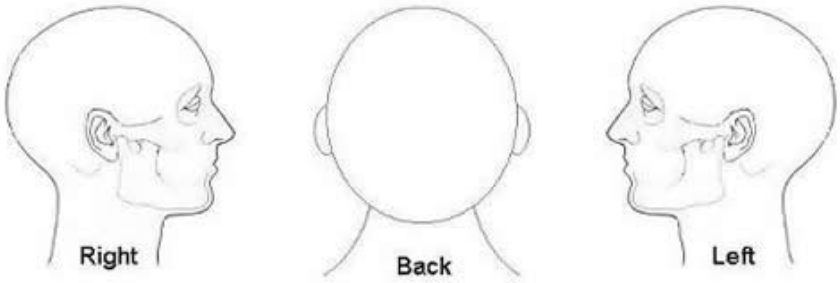
Headache #2 (If you only have 1 type of headache, you are finished)

13. Mark the areas where your head hurts for this headache type:



14. Have you had this headache type for less than 3 months? Y or N
15. How would you describe the pain? (examples: throbbing, squeezing, dull, tightness, stabbing, shooting)

    _____

16. Do you have nausea with this headache? Y or N
17. Do you have sensitivity to light with this headache? Y or N
18. Do you have sensitivity to sound with this headache? Y or N
19. Do you have sensitivity to smell with this headache? Y or N
20. Do you have changes in your vision before or during this headache? Y or N
21. Has this headache changed recently? Y or N If so, How has it changed?_____
22. What time of day are these headaches the worst? _____
23. What medicines have helped this headache?

    _____

24. Circle any of the aggravating factors below:

Caffeine	Too Much Sleep	Too Little Sleep	Weather Changes	Stress
Aspartame	Chocolate	Strenuous activity	Monosodium glutamate (MSG)	Talking
Chewing	Menstrual period	Altered eating schedule	Alcohol Intake	Neck Movement