



## HEADACHE QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. How severe are your headaches?
2. How frequent are your headaches?
3. Do they occur on waking?
4. Is there any advance warning?
5. What are the warning symptoms?
6. Where is the pain usually located?
7. Is it an aching pain, throbbing, stabbing, burning, pounding?
8. Are there other "sick" feelings?
9. Is it necessary to stop working?
10. Is relief sought in sleep?
11. How long does the headache last?
12. Is your temperature 100 degrees Fahrenheit or above?
13. Is it painful to bend your head forward and/or does light hurt your eyes?
14. Have you injured your head within the past few days?
15. Are you feeling unusually drowsy and/or have you felt nauseated or been vomiting?
16. Do you have severe pain in and around one eye and is your vision in that eye blurred?
17. Are you currently taking any medication?
18. Have you recently had or do you now have a runny or stuffy nose?
19. Do you have dull pain and tenderness around the eyes and cheekbones that worsens when you bend forward?
20. Are you feeling tense and under stress and/or are you sleeping poorly?
21. Did the headache occur after you had been reading or doing close work such as sewing?
22. Did any of the following apply in the 12 hours before the headache started?
  - a. You were exposed to strong sunlight
  - b. You were in stuffy, smoky or noisy surroundings
  - c. You drank more alcohol than usually
  - d. You missed a meal