THE HEADACHE CENTER OF SOUTHERN CALIFORNIA

Headache History & Profile Questionnaire

Name: _____ Date: _____

On what part of the head do your headaches start?

__(R) side __ (L) side __Either Side __Both Sides

__Back __ On Top __Temples __Behind/Around Eyes

__Forehead __Face __Neck __Other

How long ago did your current headache start? ___Days ___Weeks ___Months ___Years

How old were you when your headaches started? _____

How long do your headaches usually last? ___Minutes ___Hours ___Days ___Constant

How often do your headaches occur? __x/Day __x/Week __x/Month __x/Year __Constant

Is the headache getting ___More Severe ___More Frequent ___Both

After the headache starts, does it usually ___Stay in one place ___Move around

Please explain: _____

How would you describe the pain? __Throbbing __Pulsating __Pressing __Squeezing

__Stabbing __Sharp __Dull/Nagging __Other

Describe the degree of pain when your headaches **start** Slight 1 2 3 4 5 6 7 8 9 10 Worst Imaginable

Describe the degree of pain with **most** of your headaches Slight 1 2 3 4 5 6 7 8 9 10 Worst Imaginable

Describe the degree of pain with your **worst** headaches Slight 1 2 3 4 5 6 7 8 9 10 Worst Imaginable

Do your headaches interfere or prevent normal activities? Work, Social, etc… ___Yes ___No

Has your productivity at work or school been affected by your headaches? ___Yes ___No

In the **last month** have your headaches caused you to miss: Leisure/Social/Work/School? ___Yes ___No

In the **last 6 months** have your headaches caused you to miss: Leisure/Social/Work/School? ___Yes ___No

Do any blood relatives have severe headaches? ___Yes ___No If "Yes" who? _____

Do you have a history of head or neck injury? ___Yes ___No

If "Yes" did it involve loss of consciousness? ___Yes ___No

Which of the following makes the headache better?

___Rest ___Activity ___Darkness ___Quiet ___Hot Compress ___Cold Compress

___Pregnancy ___Menopause ___Scalp/Temple Pressure

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Lifestyle:

Do you exercise regularly? ___Yes ___No If yes, how often? _____

Do you frequently skip meals? ___Yes ___No

How much caffeine do you eat/drink in a day? (coffee, tea, soda, chocolate)_____

Do you smoke cigarettes? ___Yes ___No If yes, how many per day//# years ____/_____
Do you drink alcohol? ___Yes ___No If yes, how many oz per day? _____
Do you drink coffee/tea? ___Yes ___No If yes, how many cups per day? _____

Do you have problems sleeping? ___Yes ___No

Do your headaches wake you up? ___Yes ___No

Do you wake feeling rested? ___Yes ___No

Are you or have you been ___Depressed ___Anxious

Associated Headache Symptoms:

Are any of the following symptoms associated with your headaches? **Please mark (B) before (D) during (A) after**

___Spots before eyes/type ___Blindness (R/L) ___Blurring (R/L) ___Eyelid droop (R/L)

___Can see only ½ of objects ___Tearing ___Double Vision ___Eye redness (R/L)

___Puffy Eyes (R/L) ___Light sensitivity ___Noise sensitivity ___Odor sensitivity

___Stuffy nose ___Runny nose

Abdominal

___Nausea ___Vomiting ___Stomach cramps
___Hunger ___Loss of appetite ___Diarrhea

Face/Scalp

___Pale ___Redness ___Sweating ___Tender

___Pain while chewing ___Puffy ___Decreased jaw opening

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State of mind

___Depression ___Fatigue ___Anxiety

___Irritability ___Difficulty concentrating ___Difficulty talking (finding words)

___Difficulty understanding ___Fainting (feeling like or actually) ___Dizzy

Hands and or feet

___Cold ___Pale ___Sweaty ___Mottled

Weakness (W) Numbness (N) Both (B)

___Face (R/L) ___Arms (R/L) ___Legs (R/L) ___Arm & Leg (R/L)

Indicate if any of the following factors have:
(+) brought on a trigger or (++) worsen your headache

___Sleep too much/too little	___Sexual Activity	___Chocolate	___Medication (list)
___Emotional stress	___Missed meals	___Citrus fruit	___Menstrual Periods
___Depression/Anxiety	___Change in weather	___Cheeses	___Pregnancy
___Physical Activity	___Seasons	___MSG	___Menopause
___Erect position	___Alcohol	___Other foods (list)	___Oral Contraceptives
___Bending over	___Processed meats	___Straining	___Coughing