Neurology Headache Questionnaire

Patient’s Name: ___________________________ Date: ______________

1. Did the headaches start after an accident, illness or infection?

2. How long has the patient had these headaches?

3. Are the headaches constant or do they come and go?

4. How often do the headaches occur? (daily, weekly, monthly)

5. Do the headaches occur at a certain time of the day? ______ morning ______ afternoon ______ night

6. Are the headaches becoming stronger, lasting longer or occurring more frequently?

7. Do the headaches ever wake up the patient up when he is sleeping?

8. Does rest or sleep relieve the headache?

9. Do the headaches stop the patient from doing things? (like playing, watching TV, going outside or doing homework.)

10. Has the patient ever missed school or work because of a headache?

11. Is the headache pain intense when it starts, or does it start out small and builds up?

12. Please check all of the things that bring on the headaches:

   ____ Odors (Perfume, cigarettes)  ____ Fatigue  ____ School
   ____ Hunger (missing meals)  ____ Loud noises  ____ Anxiety or stress
   ____ Exercise or playing  ____ Ice Cream  ____ Family problems
   ____ Too much sleep (sleeping in)  ____ Bright Lights  ____ Menstrual cycles
   ____ Too little sleep (staying up late)  ____ Sunshine  ____ Birth Control Pills
   ____ Riding in a car  ____ Hot weather  ____ Alcohol (wine, beer)
   ____ Medications  Which ones? __________________________________________
   ____ Certain foods  Which ones? ____________________________________________
                  (for example: chocolate, peanut butter, eggs, milk, pizza, etc.)

13. Are nasal congestion, sinusitis or allergies associated with the headache?

14. Are there any warning signs BEFORE the headache begins?

   ____ Paleness  ____ Mood swings (either high or low)  ____ Irritability
   ____ Dizziness  ____ Tired, sleepy, or yawning  ____ Increased appetite
   ____ Rings around the eyes  ____ Hyperactivity  ____ Craving sweets
   ____ Eye problems (like blurred vision, black spots, flashing lights, or double vision)
15. Where is the headache located?
- Left side
- Right side
- Neck
- Forehead
- Temples
- All around the head
- Top of the head
- Back of the head
If the pain is another part of the head please describe or mark the location:

16. What does the pain feel like?
- Throbbing or pounding (like a hammer)
- Exploding
- Sharp
- Tightness (like a rubber band wrapped around the head)
- Aching
- Dull
- Pressure
- Dull

Please describe the pain in your own words:

17. Are there any other symptoms when the patient has a headache?
- Nausea
- Stomach pains
- Vomiting
- Weakness in the arms or legs
- Confusion
- Numbness in the arms or legs
If there are any other symptoms, please describe them:

18. Who else in the family has had headaches, migraines, sick headaches, motion sickness, “brain freeze” from eating ice cream or had trouble taking Birth Control Pills because of headaches?

19. Describe any stresses in the last year
(such as separation, divorce, job changes, moves, death in the family, or poor grades).

20. Who has treated the patient for headaches? When were they treated?

What tests were done?
- CT scan
- MRI
- Spinal Tap
- Eye Exam
- Dental exam
- Allergy Tests
- Sinus X-rays
- Allergy tests
- Blood tests etc.)

Any other tests?:

21. What medications or treatments have you tried? (glasses, allergy shots, chiropractor, herbal medicines, Motrin, Tylenol, prescription medicines, etc.)

23. What questions do you have about the patient’s headaches? What worries you the most?
What medical tests, medicines or therapies do you want to know about?
# Neurology Headache Diary

*(please copy this form as often as you need to)*

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Germantown, TN 38138  
(901) 572-3081 Fax: (901) 572-5090  
www.memphisneurology.com

| Name: | Chart No: |
| Current Medicine: | Starting Date: |
| Current Medicine: | Starting Date: |

<table>
<thead>
<tr>
<th>Day Date &amp; Time</th>
<th>How long did it last?</th>
<th>Severity <em>(1-&gt;10)</em></th>
<th>Where is it?</th>
<th>Description † see below</th>
<th>Triggers **see below</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday 6/27 6:30pm</td>
<td>3 hours</td>
<td>5 +</td>
<td></td>
<td>pounding light sensitive vomited</td>
<td>hot weather skipped lunch</td>
<td>Motrin, rest, ice</td>
</tr>
</tbody>
</table>

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**Severity:**  
1 = very mild  
3 = mild  
5 = moderate  
8 = severe  
10 = worst headache ever

**Description:** pounding, aching, stabbing, nausea, vomiting, sensitive to light or sound, squeezing, explosive

**Triggers:**

- **Emotions:** stress, anxiety
- **Sleep:** too much, too little
- **Environment:** cigarettes, perfumes, bright lights, riding in the car
- **Weather:** hot days, cold days, windy days, rain
- **Dietary:** caffeine drinks, chocolate, aged cheese (blue, cheddar), hot dogs, bacon, peanuts, MSG, chinese food, artificial sweetener, ice cream, skipping meals, alcohol, red wine
- **Hormonal:** menstrual cycles, birth control pills

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*For Example*: