

HEADACHE MEDICINE
NEW PATIENT QUESTIONNAIRE

Name _____

Date _____

Age your headaches began _____ (or how long ago did they start? _____)

Do you have more than one type of headache? ☐ Yes ☐ No

If yes, answer the following questions about your most disabling headache type.

Do you get any of the following symptoms hours to days before the headache starts?

☐ Food cravings or hunger ☐ Unexplained mood change ☐ Uncontrollable yawning

☐ Excessive thirst ☐ Excessive urination ☐ Drowsiness ☐ Euphoria ☐ Other _____

What parts of your head and neck hurt? _____

What does it feel like (aching, throbbing, etc)? _____

How often do your headaches occur? _____

How long do they last? On average _____ Longest _____ Shortest _____

How severe is your pain? Mild _____ Moderate _____ Severe _____

Do you have any warning before the pain starts (aura)? ☐ Yes ☐ No

If yes, describe _____

Do you have any of the following **with your headaches** (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Nausea or inability to eat | <input type="checkbox"/> Worsening with activity (walking, climbing stairs) |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Numbness or tingling <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Weakness on one side of the body/face |
| <input type="checkbox"/> Sensitivity to noise | <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Imbalance |
| <input type="checkbox"/> Sensitivity to odors | <input type="checkbox"/> Confusion <input type="checkbox"/> Spinning dizziness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Tearing from the eye(s) <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Stuffy nose | <input type="checkbox"/> Bloodshot eye(s) <input type="checkbox"/> Droopy eyelid |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Restlessness <input type="checkbox"/> Other _____ |

Do your headaches ever awaken you from sleep? ☐ Yes ☐ No *If yes, at what time?* _____

Do you have to/prefer to lie down with your headaches? ☐ Yes ☐ No

Do any of the following worsen your headaches?

- ☐ Coughing ☐ Sneezing ☐ Laughing ☐ Lifting ☐ Straining or bearing down
- ☐ Sexual activity

Are your headaches better at any particular time of the day? _____

Are your headaches worse at any particular time of day? _____

Is your headache severity affected by lying down, sitting or standing? _____

Have you identified anything that triggers your headaches? ☐ Yes ☐ No

If yes, list: _____

Describe: _____

What medications have you tried for *prevention of headache* (take it daily to prevent headaches)?

Medication	Highest dose taken (mg)	How long did you use it?	Was it effective?	Side effects

ALLODYNIA QUESTIONNAIRE (ASC-12)					
How often do you experience increased pain or an unpleasant sensation on your skin during your most severe type of headache when you engage in each of the following?	Does not apply to me	Never	Rarely	Less than half the time	Half of the time or more
	Score: 0	Score: 0	Score: 0	Score: 1	Score: 2
Combing your hair					
Pulling your hair back (e.g., ponytail)					
Shaving your face					
Wearing eyeglasses					
Wearing contact lenses					
Wearing earrings					
Wearing a necklace					
Wearing tight clothing					
Taking a shower (when the water hits your face)					
Resting your face or head on a pillow					
Exposure to heat (e.g., cooking, washing your face with hot water)					
Exposure to cold (e.g., using an ice pack, washing your face with cold water)					
Total Score					
Sum of total scores					
For office use only: 0-2 none, 3-5 mild, 6-8 moderate, 9+ severe					

MIDAS DISABILITY ASSESSMENT

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you.

INSTRUCTIONS: Please answer the following questions about all your headaches **over the last 3 months**. Write your answer- **one number, not a word or a range** - in the box next to each question. Write zero if you did not do the activity in the past **3 months**. If you don't keep a headache calendar, provide your best estimate.

	DAYS (one number per box)
1. On how many days in the last 3 months did you miss work or school because of your headaches? (If you did not attend work or school enter zero in the box.)	
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school. If you do not attend work or school enter zero in the box.)	
3. On how many days in the last 3 months did you not do household work because of your headaches?	
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days counted in question 3, where you did not do household work.)	
5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches?	
TOTAL (Questions 1-5)	
A. On how many days in the last 3 months did you have a headache? (If headache lasted more than one day, count each day.)	
B. On a scale of 0-10, on average, how painful were these headaches? (Where 0=no pain at all, and 10=pain which is as bad as it can be.)	
For office use only: 0-5 Little to none, 6-10 mild, 11-20 moderate, 21+ severe	

STOP-BANG QUESTIONNAIRE FOR SLEEP APNEA RISK			
Fill out starred (*)/shaded items			
		YES	NO
*S	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?		
*T	Do you often feel tired , fatigued, or sleepy during the daytime?		
*O	Has anyone has ever observed you stop breathing during your sleep?		
*P	Do you have or are you being treated for high blood pressure ?		
B	Is your body mass index greater than 35 kg/m2?		
*A	Are you older than 50 years?		
N	Does your neck measure more than 15¾ inches (40 cm) around?		
*G	Is your gender male?		
		Total Yes =	
For office use only: High risk of OSA: answering yes to 3 or more items Low risk of OSA: answering yes to less than 3 items			

GENERAL ANXIETY DISORDER SCALE (GAD-7)				
Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
	Score: 0	Score: 1	Score: 2	Score: 3
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it's hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				
Total Score				
Sum of total scores				
If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with people?		<input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult		
For office use only: 0-4 none, 5-9 mild, 10-14 moderate, 15+ severe				

Have you been diagnosed with:

	<u>In the past</u>	<u>Currently have it</u>
Fibromyalgia	_____	_____
Irritable bowel syndrome	_____	_____
Pelvic pain	_____	_____
Temporomandibular disorder (TMJ)	_____	_____
Painful bladder syndrome	_____	_____
Bipolar disorder (manic-depressive)	_____	_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
	Score: 0	Score: 1	Score: 2	Score: 3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
Add Columns				
Sum of total scores				
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?		<input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult		
For office use only: 0-4 none, 5 -9 mild, 10-14 moderate, 15-19 moderately severe, 20+ severe				

Note: If you have NEVER had a major stressful experience in the past, score 1 for all items.
If you had a **major stressful event**, what was it? _____

When did it occur? _____

POST-TRAUMATIC STRESS DISORDER QUESTIONNAIRE (PCL-C)

Instructions to Patient: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully, put an X in the box to indicate how much you have been bothered by that problem in the past month.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
B	1. Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?					
	2. Repeated, disturbing <i>dreams</i> of a stressful experience from the past?					
	3. Suddenly <i>acting or feeling</i> as if a stressful experience <i>were happening again</i> (as if you were reliving it)?					
	4. Feeling <i>very upset</i> when <i>something reminded you</i> of a stressful experience of the past?					
	5. Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?					
C	6. Avoiding <i>thinking about or talking about</i> a stressful experience from the past or avoiding <i>having feelings</i> related to it?					
	7. Avoiding <i>activities or situations</i> because <i>they reminded you</i> of a stressful experience from the past?					
	8. Trouble <i>remembering important parts</i> of a stressful experience from the past?					
	9. <i>Loss of interest</i> in activities that you used to enjoy?					
	10. Feeling <i>distant or cut off</i> from other people?					
	11. Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?					
	12. Feeling as if your <i>future</i> somehow will be <i>cut short</i> ?					
D	13. Trouble <i>falling or staying asleep</i> ?					
	14. Feeling <i>irritable</i> or having <i>angry outbursts</i> ?					
	15. Having <i>difficulty concentrating</i> ?					
	16. Being " <i>superalert</i> " or watchful or on guard?					
	17. Feeling <i>jumpy</i> or easily startled?					

For office use only: Supports DSM: 1 B + 3C + 2D