

Patient Name

DOB:

MR #

University of Wisconsin Hospital and Clinics
American Family Children's Hospital
600 Highland Avenue · Madison, WI 53792

HEADACHE CLINIC QUESTIONNAIRE

We first want to know about **headaches you may have had earlier in your life:**

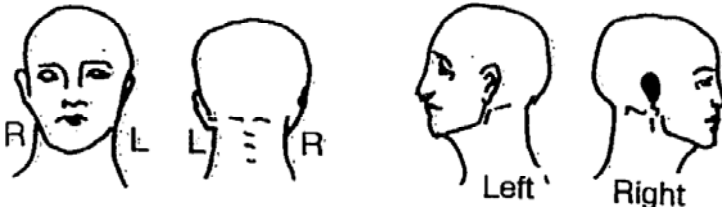
Date: _____

1. When I had my **first noticeable headache**, I was _____ years old.
2. As far as I can remember, these headaches (check all that apply):
 lasted several hours to days and made me sick were associated with visual symptoms or tingling
 were constant from the beginning

Now, we want to know about the **worst type of headaches that you have now:**

3. The headaches that I have now started _____ years/months ago.
4. They usually last: _____ minutes/hours/days they are constant (I always have a headache)
 on/off, they seem to have no pattern
5. The headaches go along with: nausea vomiting red eye eye tearing light sensitivity
 sound sensitivity runny nose _____
6. Before or during the headaches I: see zigzag lines see shimmering lights
 feel tingling (where _____?) _____
This usually lasts for _____ minutes/hours for the entire headache
7. During the headache, I go to bed or try to avoid physical activity (for instance, going up a flight of stairs)
 Yes No

8. The headaches are usually located (circle):



9. The headaches are usually: stabbing pounding pulsating burning pressure/vice like
 like a knife other _____
10. The headaches can be triggered by: coughing sneezing having a bowel movement exercise
 oversleeping not sleeping enough weather change sexual activity
 certain foods _____ _____

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11. Did you ever have headaches that were clearly triggered by getting into upright position, and stopped just from laying flat a few minutes (positional headaches)? Yes No

12. Over the past 2 months, due to headaches, I missed _____ days of work, and I went to the ER (Emergency Room) _____ times

13. Medical History: _____

14. Surgical History: _____

15. Family History

| Family Member | Migraines or other strong headaches (✓) | Other important medical problems |
|----------------|---|----------------------------------|
| Father | | |
| Mother | | |
| Brother/sister | | |
| Brother/sister | | |
| Brother/sister | | |
| Brother/sister | | |
| Brother/sister | | |
| Child | | |
| Child | | |
| Child | | |
| | | |
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16. On average, I drink about _____ caffeinated beverages per day.

17. I never smoked I smoke or did smoke _____ (packs of cigarettes/cigars/pipes) per day for _____ yrs
If applicable, date that you quit smoking ____/____/____

18. I have _____ alcoholic drink(s) per day/week/month

19. I had (or currently have) a problem with alcohol or drugs Yes No

20. I use or did use recreational drugs: Cannabis Cocaine Heroin Amphetamines Other _____

21. Do you have problems with any of the following, **now or recently**, related to the headaches or completely unrelated? Please **place a ✓ and explain** details if needed.

- Heart (e.g. funny heart beats, chest pain)
- Lungs (cough, shortness of breath)
- Bowel or bladder
- Skin
- Hearing (e.g. hearing loss, ear noise)
- Vision/eyes (e.g. double vision)
- Mind/mood (anxiety, depression)
- Balance
- Memory/concentration/cognition
- Numbness, tingling
- Involuntary weight loss, fatigue
- Joint pain or swelling
- Swollen glands
- Jaw/chewing
- Pain elsewhere
- Other

22. Which doctors have been involved in treating your headaches so far? _____

23. Which tests/scans did you undergo so far, if any: _____

24. What do you think is causing your headaches, or what do you suspect is your diagnosis? _____

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25. What do you expect from this visit? _____

26. What medications did you try for your headaches?

Acute/abortive drugs (medications that you take in order to stop the headache that you have right now) that you took for headaches:

| Drug | Dose | Result (NE-not effective, NT=not tolerated) |
|---|----------|---|
| Ibuprofen (Advil TM) | | |
| Hydrocodone/APAP (Vicodin TM , Norco TM) | | |
| Ketorolac (Toradol TM) | | |
| Sumatriptan (Imitrex TM) tablets | | |
| Sumatriptan (Imitrex TM) injection | 4 mg 6mg | |
| Zolmitriptan (Zomig TM) | | |
| Almotriptan (Axert TM) | | |
| Rizatriptan (Maxalt TM) | | |
| Eletriptan (Relpax TM) | | |
| DHE (Migranal TM) | | |
| Treximet TM | | |
| | | |
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Preventive drugs (medications that you take/took every day for your headaches, regardless of whether you have a headache that day or not):

| Drug | Max. dose per day | Tried for how many months/weeks | Result (NE= not effective, NT= not tolerated) |
|-------------------------------------|-------------------|---------------------------------|---|
| Topiramate (Topamax TM) | | | |
| Valproate (Depakote TM) | | | |
| Propranolol or other beta blocker | | | |
| Verapamil (Isoptin TM) | | | |
| Amitriptyline or Nortriptyline | | | |
| Lithium | | | |
| Prednisone or other steroids | | | |
| Gabapentin | | | |
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