

Staple

3-Hole 1/4 1 3/8 c-to-c

Patient Name:

DOB:

MR #:

Date: \_\_\_\_\_

**University of Wisconsin Hospital and Clinics**  
600 Highland Avenue • Madison, Wisconsin 53792  
**UW HEADACHE CLINIC QUESTIONNAIRE**

**TO ALL HEADACHE CLINIC PATIENTS:**

We would appreciate your cooperation in filling out this form. In our evaluation of headaches, your history is typically our most valuable tool for diagnosis and subsequent treatment. If you have any questions regarding this form, please call 608-263-9550.

**A. Identification**

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Sex: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

**Who is your primary physician?** \_\_\_\_\_

Address (if known): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

**Pharmacy Name** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

**B. Headache History**

How old were you when you had your first significant headache? \_\_\_\_\_

Over the past 6 months, how many individual headache attacks have you averaged per month? \_\_\_\_\_

Has there been any change in the last 12 months in the character or frequency of your headaches? No \_\_\_ Yes \_\_\_

If yes, please specify what type of change: \_\_\_\_\_

Do you have a headache every day? If so, for how long? \_\_\_\_\_

Is your headache localized to one side? No \_\_\_ Yes \_\_\_

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Are you currently receiving formal treatment (counseling and/or medications) for anxiety or depression? No \_\_\_ Yes \_\_\_

Do you sleep at regular intervals? No \_\_\_ Yes \_\_\_

Do you eat at regular intervals? No \_\_\_ Yes \_\_\_

Do you adhere to a regular exercise program? No \_\_\_ Yes \_\_\_

Do you consider yourself to be currently under a significant amount of stress? No \_\_\_ Yes \_\_\_

Are you currently having difficulties with your sleeping (insomnia, early morning awakening, "always sleepy", etc.)? No \_\_\_ Yes \_\_\_

**C. Medical and Social History**

What seems to help your headache? \_\_\_\_\_

What makes your headache worse? \_\_\_\_\_

extreme thirst, food cravings (Please describe: \_\_\_\_\_)

vertigo (i.e., a spinning / "merry-go-around" sensation)

loss of balance

speech disturbance (Please describe: \_\_\_\_\_)

numbness and/or tingling in face, arm, or leg (Please describe: \_\_\_\_\_)

inability to tolerate loud noise (phonophobia)

inability to tolerate bright light (photophobia)

(Please describe: \_\_\_\_\_)

visual changes (e.g., visual distortion, "flash cubes", "zig-zags", "blind spots", "sparkles").

vomiting

nausea

Please check the appropriate boxes:

Do you ever experience any of the following symptoms in association with your headache attacks (before, during, or after)?

(If yes, what type of warning do you have? \_\_\_\_\_)

Do you have any warning symptoms which alert you that you are going to have a headache attack? No \_\_\_ Yes \_\_\_

Do you have headaches associated with menses? \_\_\_\_\_

(If yes, please describe \_\_\_\_\_)

Does your headache typically occur at a certain time of day or on certain days of the week or month? No \_\_\_ Yes \_\_\_

Do you wake up with a headache? No \_\_\_ Yes \_\_\_

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Please check the appropriate boxes:

- history of snoring
- history of lung disease
- anemia
- hypertension (high blood pressure)
- arthritis
- history of thyroid disease
- treated for depression in past
- recent weight loss
- recent weight gain
- past or present problems with significant motion sickness
- do you smoke cigarettes now? (Number of cigarettes per day) \_\_\_\_\_
- any significant head injury? (if yes, within the past six months? No\_\_\_ Yes\_\_\_ )
- history of seizures
- any other significant medical or psychiatric problem or conditions for which you are under medical care? No\_\_\_ Yes\_\_\_

If yes, please explain: \_\_\_\_\_

Do you take oral contraceptives or estrogen replacement therapy? No\_\_\_ Yes\_\_\_ (If yes, effect on your headaches? Better\_\_\_ worse\_\_\_ no change\_\_\_ can't recall\_\_\_ )

Are you pregnant? No\_\_\_ Yes\_\_\_ (If yes, effect on your headaches? Better\_\_\_ worse\_\_\_ no change\_\_\_ can't recall\_\_\_ )

Have you seen a specialist in the past for your headaches? No\_\_\_ Yes\_\_\_ His/Her diagnosis (if known): \_\_\_\_\_

Have you had a CAT scan/MRI in the past? No\_\_\_ Yes\_\_\_ unknown\_\_\_

What medications have you tried in the past for your headaches (e.g., Inderal, Cafergot, and Elavil)? \_\_\_\_\_

What are your current medications(dosages) including supplements? \_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

If not completed by patient, relationship to patient: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Provider Declaration:** I have reviewed this document in detail and have discussed its contents with the patient. (Provider sign and date below)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you! Please sign below.

What do you want to accomplish with your visit to us?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you think is causing your headache?

\_\_\_\_\_

**F. Final Questions**

How long have/had you been at this job? \_\_\_\_\_ how much do/did you like it? \_\_\_\_\_

Have you been off work because of your headaches in the past? No \_\_\_ Yes \_\_\_. If so, how many times and for how long? \_\_\_\_\_

Have you ever had a problem with alcohol or drug use? No \_\_\_ Yes \_\_\_. If yes, please explain \_\_\_\_\_

Have you ever been treated for alcohol or drug abuse? No \_\_\_ Yes \_\_\_. If yes, when and where? \_\_\_\_\_

What is your present or previous occupation? \_\_\_\_\_

Do you work: Fulltime \_\_\_\_\_ Part time \_\_\_\_\_ Light or limited duty \_\_\_\_\_ Explain \_\_\_\_\_

**E. About Your Life**

Has anyone in your family had a significant problem with headaches or been diagnosed as having migraine or "sick" headaches? No \_\_\_ Yes \_\_\_ (if yes, who? \_\_\_\_\_) (unknown \_\_\_\_\_)

**D. Family History**

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DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_