It may seem strange to ask a person where his headache hurts, but the exact location in the head is important to help us make an accurate diagnosis. Please read through the entire history, then answer each question to the best of your ability and as accurately as possible. If uncertain, leave blank.

1. Location

Indicate the area of your head where your headaches seem to be concentrated. Please check those that apply:

____ A. Always on one side       ( R ) _____ ( L ) _____
____ B. Alternates
____ C. Always on both sides
____ D. Over eyes
____ E. In eyes
____ F. Under eyes
____ G. Between eyes
____ H. Behind eyes
____ I. In temples
____ J. In teeth
____ K. Over cheeks
____ L. In top of head
____ M. In side of head
____ N. In back of head
____ O. In neck - back
____ P. In ears
____ Q. Other ________________________________

2. How long have you had these headaches?

__________________________________________________________

A. They have become:
   ____ More Severe
   ____ Less Severe
   ____ Same Severity
   ____ More Frequent

B. They occur:
   ____ 1. Daily
   ____ 2. Weekly
   ____ 3. Monthly
   ____ 4. Periodic (several headaches followed by period of no headaches, only to recur several months later).
C. They begin:
   ____ 1. Slowly (over 20-30 minutes).
   ____ 2. Abruptly

D. They last:
   ____ 1. Seconds
   ____ 2. Minutes
   ____ 3. Hours
   ____ 4. Days

3. Headaches occur most often: (Please check appropriate blank).
   ____ A. Upon awakening in A.M.
   ____ B. Awakened in A.M. by headache
   ____ C. After getting up
   ____ D. Late morning
   ____ E. Later in day
   ____ F. Late afternoon
   ____ G. In evening
   ____ H. Awaken from sleep about 1-3 hours after going to bed
   ____ I. (In Females) In association with monthly periods
   ____ J. Every day for several days, then no headaches for periods of time
   ____ K. Just before meals
   ____ L. 1-2 hours after meals
   ____ M. Do you ever miss or skip meals and have headaches occur at time of normal meals?
   ____ N. Several hours after missing usual meal hour
   ____ O. Other ________________________________

4. Headache pain best described as:
   ____ A. Steady
   ____ B. Pulsating
   ____ C. Throbbing
   ____ D. Shooting (if so, write from where to where) ____________________________________________
   ___ E. Other ________________________________

5. Headaches are accompanied by: (Please check Yes or No)

YES  NO
___  ____ A. Blockage or obstruction to breathing through nose.
   ___  ____ 1. If headache on only one side, nose obstructs same side
   ___  ____ 2. Both sides
   ___  ____ B. Runny nose
   ___  ____ 1. If headache on only one side, runny nose on same side.
   ___  ____ 2. Both sides
   ___  ____ C. Redness and watering of eye
   ___  ____ 1. If headache on only one side, the side of headache
   ___  ____ 2. Both sides
D. Changes in eyesight with headaches
   1. Flashes of light
   2. Decreased area of vision (tunnel vision)
   3. Double vision

E. Gastro-intestinal Symptoms
   1. Nausea
   2. Vomiting
   3. Abdominal cramps
   4. Diarrhea

F. Chest symptoms
   1. Chest pain
   2. Shortness of breath
   3. Difficulty breathing

6. List ALL medications you now take including non-prescription drugs (and birth control pills if taken).

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

7. Is there anything that you know of that brings on a headache?

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

8. Is there anything that you know of that aggravates a headache?

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

9. Is there anything that makes your headache better?

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

10. Does reading or close work make headaches worse?

11. Does exertion make headaches worse?

12. Do you have any of the following diseases?

   YES   NO
   ____   ____  1. Arthritis
   ____   ____  2. Rheumatic disease
   ____   ____  3. High blood pressure (Hypertension)
   ____   ____  4. Diabetes
   ____   ____  5. Chronic kidney disease
   ____   ____  6. Ulcers of the stomach
   ____   ____  7. Asthma
   ____   ____  8. Hay fever
   ____   ____  9. Food allergies
   ____   ____ 10. Chronic constipation
13. Please list all illnesses you have had for the past 3 years. ______________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

14. Do you smoke? ___________________________________
What? __________________________________________
How many? ______________________________________

15. Do you use alcohol? _______________________________
How much per day? _________________________________
What form or forms?
Beer _____________________ Scotch _____________________
Wine _____________________ Gin _____________________
Bourbon __________________ Vodka _____________________
Other _____________________________________________

16. Does headache ever occur within 30 minutes after use of alcohol? _______________________________
YES NO
____ ____

17. Have you ever had a severe head injury?
When? ___________________________________________
What? ___________________________________________
How? ___________________________________________
____ ____

18. Have you ever had a severe neck injury?
When? ___________________________________________
What? ___________________________________________
How? (Auto accident, sports, fall, etc.) _____________________
____ ____

19. Do you have:
YES NO
____ ____ A. Feelings of tenseness of anxiety with no real cause
____ ____ B. Financial problems
____ ____ C. Marital problems
____ ____ D. Problems with neighbors
____ ____ E. Problems with employer
____ ____ F. Problems with fellow employees
____ ____ G. Problems with children
____ ____ H. Problems with in-laws
____ ____ I. Other _______________________________________
____ ____

____________________________________________________
____________________________________________________