

HEADACHE HISTORY

Name _____ Date _____

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
- _____ Less Frequent
- _____ Same Frequency

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 | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Blockage or obstruction to breathing through nose. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. If headache on only one side, nose obstructs same side |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Both sides |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Runny nose |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. If headache on only one side, runny nose on same side. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Both sides |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Redness and watering of eye |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. If headache on only one side, the side of headache |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 _____

