Dear Patient,

Your appointment with Dr. __________________________ has been scheduled for:
Date: _________________________ Time: ________________________

Enclosed is an extensive questionnaire to help evaluate your headaches.

By completing as much as you can, you allow us to maximize your time with us at the Stanford Headache clinic and focus on creating the best possible treatment plan for you headache.

The forms are long and detailed but also necessary. Some parts of the questionnaire may seem redundant or repetitive. We are aware of this and there are reasons for the questionnaire being structured the way it is. There may also be parts of the questionnaire that do not seem clear or do not apply to you. Just leave them blank, and when you arrive for your appointment, we will go over those parts with you.

In order to serve you better we request that you mail or bring the completed questionnaire to the clinic at least one week before your appointment.

Thank you,

Rob Cowan MD, FAAN
Director
Headache Clinic

Meredith Barad MD
Clinical Instructor
Anesthesia

Pre appointment Check List

- Stanford Neuroscience Clinic is part of a teaching institution. You may see more than one physician, nurse, or trainee.
- While you are waiting in the examination room the team will be reviewing records that have been provided as well as discussing diagnosis and treatment recommendations for your condition.
- Please fill out the enclosed Patient History form. Having this information completed prior to arrival will avoid delay and assist your physician in understanding your health needs.
- **It is important to communicate the prescriptions and medications you are taking. Please be sure to complete the prescription section at the end of the form and bring it with you to your clinic visit.**
- If an interpreter has not been scheduled for your appointment, and you would like one present, please call 650 725-5792 with this request at least 24 hours in advance.
- If you are unable to keep this appointment or no longer need it, please call (650) 723-6469 to cancel. We can then make this time available to other waiting patients. We will assist you in rescheduling, if necessary.
- Allow plenty of time to find your way to the area, park, check-in and complete any additional paperwork. Maps & directions are available on http://stanfordhospital.org/headache. Paid parking is available.

Print Last Name:
Print First Name:
Date of Birth:
Today's Date:
Appointment Date:

Initial Screening Questions for Headache Patients

Do you EVER have headaches as a result of:

Question			
1. Skipped meals or overeating?	☐ Yes	☐ No	☐ Don't know
2. Too much or too little fluid intake?	☐ Yes	☐ No	☐ Don't know
3. Alcoholic beverage ingestion?	☐ Yes	☐ No	☐ Don't know
4. Too much or too little caffeine?	☐ Yes	☐ No	☐ Don't know
5. Too much or too little sleep?	☐ Yes	☐ No	☐ Don't know
6. Infections (including flu, cold, fever, etc.)	☐ Yes	☐ No	☐ Don't know
7. Stress or relief from stress?	☐ Yes	☐ No	☐ Don't know
8. Allergies?	☐ Yes	☐ No	☐ Don't know
9. Menstrual cycle?	☐ Yes	☐ No	☐ Don't know
10. High Altitude?	☐ Yes	☐ No	☐ Don't know
11. Medications (including OTC, supplements)	☐ Yes	☐ No	☐ Don't know
12. Head Injury?	☐ Yes	☐ No	☐ Don't know
13. Bright lights, loud sounds, strong smells?	☐ Yes	☐ No	☐ Don't know
14. Driving at night?	☐ Yes	☐ No	☐ Don't know

Print Last Name:
Print First Name:
Date of Birth:
Today's Date:
Appointment Date:

Headache Questionnaire

How old were you when you remember having your first troublesome headache?

Do you think you have more than one type of headache? ☐ Yes ☐ No ☐ Maybe
If so, how many different kinds of headaches do you have?

Please think about your *__most troublesome__* headaches when answering all of the following questions:

I. *Past Year* Headache Information

a. Over the past year, what would you estimate to be the average frequency of these headaches?
headaches per week / month / year (circle one)

b. Over the past year, on a scale of 0 to 10, with 0 meaning "no pain" and 10 meaning "the worst pain imaginable," what would you estimate to have been the average severity of your headaches?

No pain									Worst pain imaginable
1	2	3	4	5	6	7	8	9	10

c. Over the past year, what has been the average duration of your headaches?
Minutes / Hours / Days (circle one)

II. *Lifetime* Headache Information

a. What would you estimate to have been the average frequency of your headaches since they began?
headaches per week/month/year (circle one)

b. Has the frequency of your headache changed over the years? ☐ Yes ☐ No
If yes, please give details regarding periods of remission or increased frequency, severity etc.)

c. Over the years since your headaches began, what would you estimate to have been their average severity on a scale of 0 to 10, with 0 meaning "no pain" and 10 meaning "the worst pain imaginable"?

No pain									Worst pain imaginable
1	2	3	4	5	6	7	8	9	10

d. Throughout the years you have had these headaches, what has been their overall average duration?
Minutes / Hours / Days (circle one)

III. Qualitative Characteristics of Headache

a. Which of these phrases best describes the pain of these headaches?

- ☐ Worst pain possible
- ☐ Very severe pain
- ☐ Severe pain
- ☐ Moderate pain
- ☐ Mild pain
- ☐ No pain

b. Which of these words best describe the sensation of pain during this type of headache? (Check all that apply)

☐ Throbbing	☐ Stabbing	☐ Stinging
☐ Sharp	☐ Pounding	☐ Tingling
☐ Pressure	☐ Pinching	☐ Burning
☐ Heavy	☐ Dull	☐ Cramping
☐ Sore	☐ Aching	☐ Piercing
☐ Pulsating	☐ Splitting	☐ Tender
☐ Shooting	☐ Tight	☐ Other

c. Does your headache pain typically begin on one side of your head?

☐ Yes ☐ No ☐ Sometimes ☐ Don't Know

d. In the midst of your headache, do you feel pain on one side or both sides of your head?

☐ One side ☐ Both sides ☐ Variable ☐ Don't Know

e. If you feel pain on one side of your head, which of these best describes its location?

☐ Usually left side	☐ Usually right side
☐ Always left side	☐ Always right side
☐ Can be either side	☐ Other

f. Where do you typically feel the worst of your headache pain?

☐ Temple(s)	☐ Base of neck
☐ Back of head	☐ Front of head
☐ Behind the eye(s)	☐ Top of head
☐ Don't Know	☐ Other

g. Does routine physical activity, such as walking up stairs, make your headache worse?

☐ Yes ☐ No ☐ Sometimes ☐ Don't Know

h. Is your headache affected by sexual activity?

☐ Yes ☐ No ☐ Sometimes ☐ Don't Know

i. Which of the following symptoms do you experience with your most troublesome headaches?

Symptom	Frequency (circle one)				Impact on your lifestyle (circle one)			
Scalp tenderness	Never	Rare	Often	Always	None	Minor	Moderate	Major
Neck stiffness/tenderness	Never	Rare	Often	Always	None	Minor	Moderate	Major
Shoulder stiffness	Never	Rare	Often	Always	None	Minor	Moderate	Major
Aching spine	Never	Rare	Often	Always	None	Minor	Moderate	Major
Swollen breasts	Never	Rare	Often	Always	None	Minor	Moderate	Major
Fever	Never	Rare	Often	Always	None	Minor	Moderate	Major
Chills	Never	Rare	Often	Always	None	Minor	Moderate	Major
Flushing	Never	Rare	Often	Always	None	Minor	Moderate	Major
Night sweats	Never	Rare	Often	Always	None	Minor	Moderate	Major
Dizziness	Never	Rare	Often	Always	None	Minor	Moderate	Major
Faintness	Never	Rare	Often	Always	None	Minor	Moderate	Major
Weakness	Never	Rare	Often	Always	None	Minor	Moderate	Major
Insomnia	Never	Rare	Often	Always	None	Minor	Moderate	Major
Fatigue	Never	Rare	Often	Always	None	Minor	Moderate	Major
Irritability	Never	Rare	Often	Always	None	Minor	Moderate	Major
Mood change	Never	Rare	Often	Always	None	Minor	Moderate	Major
Personality change	Never	Rare	Often	Always	None	Minor	Moderate	Major
Mental exhaustion	Never	Rare	Often	Always	None	Minor	Moderate	Major
Physical exhaustion	Never	Rare	Often	Always	None	Minor	Moderate	Major
Loss of appetite	Never	Rare	Often	Always	None	Minor	Moderate	Major
Nausea	Never	Rare	Often	Always	None	Minor	Moderate	Major
Vomiting	Never	Rare	Often	Always	None	Minor	Moderate	Major
Diarrhea	Never	Rare	Often	Always	None	Minor	Moderate	Major
Constipation	Never	Rare	Often	Always	None	Minor	Moderate	Major
Stomach ache	Never	Rare	Often	Always	None	Minor	Moderate	Major
Sensitivity to odor	Never	Rare	Often	Always	None	Minor	Moderate	Major
Nasal congestion	Never	Rare	Often	Always	None	Minor	Moderate	Major
Nose bleed	Never	Rare	Often	Always	None	Minor	Moderate	Major
Excessive urination	Never	Rare	Often	Always	None	Minor	Moderate	Major
Redness/ tearing of eyes	Never	Rare	Often	Always	None	Minor	Moderate	Major
Sensitivity to light	Never	Rare	Often	Always	None	Minor	Moderate	Major
Double vision	Never	Rare	Often	Always	None	Minor	Moderate	Major
Visual changes	Never	Rare	Often	Always	None	Minor	Moderate	Major
Sensitivity to sound	Never	Rare	Often	Always	None	Minor	Moderate	Major
Ringing in ears	Never	Rare	Often	Always	None	Minor	Moderate	Major
Hearing problems	Never	Rare	Often	Always	None	Minor	Moderate	Major
Drainage in ear(s)	Never	Rare	Often	Always	None	Minor	Moderate	Major
Speech changes	Never	Rare	Often	Always	None	Minor	Moderate	Major
Aching jaw or facial pain	Never	Rare	Often	Always	None	Minor	Moderate	Major
Teeth grinding	Never	Rare	Often	Always	None	Minor	Moderate	Major
Sensory changes	Never	Rare	Often	Always	None	Minor	Moderate	Major
Other:	Never	Rare	Often	Always	None	Minor	Moderate	Major
Other:	Never	Rare	Often	Always	None	Minor	Moderate	Major
Other:	Never	Rare	Often	Always	None	Minor	Moderate	Major
Other:	Never	Rare	Often	Always	None	Minor	Moderate	Major

j. If sensitivity to light and sound are both checked in the symptom table, do they occur at:
☐ The same time ☐ Different times ☐ Variable ☐ Don't know

k. If weakness and/or numbness are checked in the symptom table, do they occur on:
☐ The same side as your headache ☐ The side opposite your headache
☐ Both sides ☐ Other

l. If you have tearing or nasal congestion checked in the symptom table, does this occur on:
☐ The same side as your headache ☐ The side opposite your headache
☐ Both sides ☐ Other

IV. Quantitative Characteristics of Headache

a. Does your headache typically occur multiple times a day?
☐ Yes ☐ No ☐ Don't Know

b. How long do your headaches typically last?
☐ Less than 5 minutes ☐ 5 – 15 minutes ☐ 15 - 60 minutes
☐ 1 – 3 hours ☐ 4 – 72 hours ☐ Over 72 hours

c. At what time of day do you most often experience this headache?
☐ Morning ☐ Middle of the night
☐ Afternoon ☐ Anytime (no specific time)
☐ Evening ☐ Other

d. Do these headaches occur at a particular time of the year?
☐ Spring ☐ Summer ☐ Fall ☐ Winter
☐ Any season (year round) ☐ Other

e. What is the average number of headache-free days you experience each month?

f. How long ago did you have your last problematic headache?

g. When did you last take medication for your headache?

h. What medication did you last take (and how much)?
Medication: Amount:

V. Impact of Headache

a. On how many days in the last 3 months did you miss work or school because of your headaches? (If you do not attend work or school enter zero.)

b. 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 school or work enter zero.)

c. On how many days in the last 3 months did you not do household work because of your headaches?

d. 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 the above question, where you did not do any household work.)

e. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches?

f. Is the possibility of a headache a significant factor when you make plans?
☐ Yes ☐ No ☐ Sometimes ☐ Don't Know

g. Do you feel your headaches have changed the way you're viewed or treated by others?
☐ Yes ☐ No ☐ Sometimes ☐ Don't Know

h. Do these headaches disrupt your sleep?
☐ Yes ☐ No ☐ Sometimes ☐ Don't Know

i. Do your headaches awaken you from sleep?
☐ Yes ☐ No ☐ Sometimes ☐ Don't Know

j. Are your headaches often present upon awakening in the morning?
☐ Yes ☐ No ☐ Sometimes ☐ Don't Know

VI. Precursors of Headache

a. Do you have changes in your vision before these headaches?
☐ Yes ☐ No ☐ Sometimes ☐ Don't Know
If so, how long before the headache do your visual changes occur?

Are these visual changes present only BEFORE your headache or do they CONTINUE throughout the duration of your headache?
☐ Only before the headache ☐ Continue throughout the headache
☐ Other

How long do these visual disturbances last?
☐ Less than 4 minutes ☐ 4 – 15 minutes ☐ 15 – 60 min ☐ Over 60 minutes
Please describe these visual changes:

b. Have you noticed significant changes in your appetite before your headaches?
☐ Yes ☐ No ☐ Sometimes ☐ Don't Know
If so, how long before the headache?

c. Have you noticed significant changes in your thirst before your headaches?
☐ Yes ☐ No ☐ Sometimes ☐ Don't Know
If so, how long before the headache?

d. Do you feel burning or prickling on your skin before your headache occurs?
☐ Yes ☐ No ☐ Sometimes ☐ Don't Know
If so, how long before the headache?

e. Do you experience significant mood swings before your headache occurs?
☐ Yes ☐ No ☐ Sometimes ☐ Don't Know
If so, how long before the headache?
Please describe:

f. Do you experience any personality change before your headache occurs?
☐ Yes ☐ No ☐ Sometimes ☐ Don't Know
If so, how long before the headache?
Please describe:

g. Do you experience any other symptoms before your headache starts?
☐ Yes ☐ No ☐ Sometimes ☐ Don't Know
If so, please describe:

How long before the headache do these symptoms occur?

h. Do you drink coffee or other caffeinated drinks?
☐ Yes ☐ No ☐ Sometimes
If so, how many per day?

i. Do you notice a change in your caffeine consumption prior to your headache?
☐ Yes ☐ No ☐ Sometimes ☐ Don't Know
If so, how long before the headache?

VII. Triggers

a. Please indicate which of the following might trigger a headache (check all that apply)

Exposure to	Frequency of a headache following exposure			
	Never	Uncertain	Sometimes	Always
Stress				
Work				
Nervousness				
Fatigue				
Lack of Sleep				
Too much Sleep				
Phobias/Fears				
Pain on light touch to head				
Travel				
Weather Changes				
Missed Meals				
Chocolate				
Caffeine				
Citrus Fruits				
Cheeses				
Tobacco Smoke				
Odor (specify)				
Alcohol (specify)				
Exercise				
Sexual Functioning				
Menses				
Hormonal supplements				
Medications (specify)				
Other (describe)				
Other (describe)				

The following questions are for FEMALES only (MALES please go to page 13)

1. At what age did you begin menstruating?

2. Did you begin having headaches or experience an increase in the severity of your headaches around this age?
   ☐ Yes ☐ No ☐ Don't Know

3. Did you have any bloating at this age?
   ☐ Yes ☐ No ☐ Don't Know

4. Did you develop significant acne at this age?
   ☐ Yes ☐ No ☐ Don't Know

5. Are you still menstruating?
   ☐ Yes ☐ No ☐ Other

   If yes:
   a. What is the typical range (in days) of your bleeding?
   b. What is the most typical length (in days) between 2 bleeding periods?
   c. What was the first date of your last period?
   d. In the past year, have you noticed that your headaches worsen (either become more severe or frequent) in the week prior to your menstrual period?
      ☐ Never ☐ Some periods ☐ Don't Know ☐ Most periods ☐ Every period
   e. In the past year, have you noticed that your headaches worsen (either become more severe or frequent) in the week after the start of menstrual bleeding?
      ☐ Never ☐ Some periods ☐ Don't Know ☐ Most periods ☐ Every period
   f. In the past year, has the frequency of your periods changed?
      ☐ Yes ☐ No ☐ Don't Know
      If so, has it become: ☐ More frequent ☐ Less frequent ☐ Variable
   g. In the past year, has the flow of your periods changed?
      ☐ Yes ☐ No ☐ Don't Know
      If so, has it become: ☐ Heavier ☐ Lighter ☐ Variable

   If you are no longer menstruating:
   a. At what age was menopause?
   b. Was your menopause:
      ☐ Induced by drugs ☐ Natural ☐ Induced by surgery ☐ Other
   c. Have your headaches changed since menopause?
      ☐ Yes ☐ No ☐ Don't Know
      If so, how have your headaches changed?

6. Have you ever taken oral birth control pills? ☐ Yes ☐ No
   a. If yes, which one(s) did you use and for how long?

b. Did severe headaches begin for the first time around the time you began taking birth control pills? (circle one)

Definitely	Probably	Not sure	Probably not	Definitely not

c. As compared to your condition prior to starting birth control pills, did the severity and/or frequency of headaches increase? (circle one)

Definitely	Probably	Not sure	Probably not	Definitely not

d. During the days you took placebo pills (the last seven days of each pack), are/were your headaches more frequent or severe when you are/were not taking birth control pills? (circle one)

Definitely	Probably	Not sure	Probably not	Definitely not

7. Have you ever had hormone replacement therapy? ☐ Yes ☐ No
   a. If yes, which medication(s) did you use and for how long?

   b. Did severe headaches begin for the first time around the time you began hormone replacement therapy? (circle one)

Definitely	Probably	Not sure	Probably not	Definitely not

   c. As compared to your condition prior to starting hormone replacement therapy, did the severity and/or frequency of headaches increase? (circle one)

Definitely	Probably	Not sure	Probably not	Definitely not

8. Fluctuating hormone levels can be associated with changes in sexual drive. Have there been recent changes in your sexual desire?
   ☐ Same ☐ More ☐ Less

9. Have there been any recent changes in your body hair distribution?
   ☐ Yes ☐ No ☐ Don't Know

10. Have you ever had difficulty getting pregnant? ☐ Yes ☐ No
    a. If yes, have you ever been tested for infertility? ☐ Yes ☐ No
       i. If yes, were you or your partner diagnosed with infertility?
          ☐ Yes, I was ☐ Yes, my partner was ☐ No
          ☐ Other
       ii. Have you ever had infertility treatment?
          ☐ Yes ☐ No

11. Have you ever been pregnant? (Please consider all pregnancies including miscarriages, abortions, tubal pregnancies and stillbirths.)
    ☐ Yes ☐ No ☐ Don't Know
    a. If yes, did headaches begin, worsen or improve with any of your pregnancies?
       ☐ Yes ☐ No ☐ Don't Know

b. During the first 6 months of my pregnancy, my headaches:

Month 1	Definitely improved	Somewhat improved	Unchanged	Somewhat worsened	Definitely worsened	Don't Know	Not applicable
Month 2	Definitely improved	Somewhat improved	Unchanged	Somewhat worsened	Definitely worsened	Don't Know	Not applicable
Month 3	Definitely improved	Somewhat improved	Unchanged	Somewhat worsened	Definitely worsened	Don't Know	Not applicable
Month 4	Definitely improved	Somewhat improved	Unchanged	Somewhat worsened	Definitely worsened	Don't Know	Not applicable
Month 5	Definitely improved	Somewhat improved	Unchanged	Somewhat worsened	Definitely worsened	Don't Know	Not applicable
Month 6	Definitely improved	Somewhat improved	Unchanged	Somewhat worsened	Definitely worsened	Don't Know	Not applicable

c. During the last 3 months of my pregnancy my headaches:

Month 7	Definitely improved	Somewhat improved	Unchanged	Somewhat worsened	Definitely worsened	Don't Know	Not applicable
Month 8	Definitely improved	Somewhat improved	Unchanged	Somewhat worsened	Definitely worsened	Don't Know	Not applicable
Month 9	Definitely improved	Somewhat improved	Unchanged	Somewhat worsened	Definitely worsened	Don't Know	Not applicable

d. When my menstrual cycle resumed my headaches were:

Definitely Improved	Somewhat improved	Unchanged	Somewhat worsened	Definitely worsened	Don't Know	Not applicable

12. Have you ever breast-fed for greater than 1 week?

☐ Yes ☐ No ☐ Don't Know

a. If yes:

i. For how long did you breast-feed after each birth? (describe in weeks, months, years)

ii. Compared to my headaches during the last 3 months of this pregnancy, my headaches while breast feeding were:

Definitely improved	Somewhat improved	Unchanged	Somewhat worsened	Definitely worsened	Don't Know	Not applicable

iii. Compared to my headaches before I was pregnant with this child, my headaches during the time I breastfed were:

Definitely improved	Somewhat improved	Unchanged	Somewhat worsened	Definitely worsened	Don't Know	Not applicable

iv. After I stopped breast-feeding and my menstrual cycle resumed, my headaches were:

Definitely improved	Somewhat improved	Unchanged	Somewhat worsened	Definitely worsened	Don't Know	Not applicable

The following questions are for MALES only (FEMALES please go to page 15)

1. At approximately what age did you begin puberty? (e.g., voice deepening, pubic hair developing…)
   a. Did you begin having headaches or experience an increase in the severity of your headaches around this age?
      ☐ Yes ☐ No ☐ Don't Know
   b. Did you develop significant acne at this age?
      ☐ Yes ☐ No ☐ Don't Know
   c. Did you have any bloating at this age?
      ☐ Yes ☐ No ☐ Don't Know
   d. Did your breasts swell at this age?
      ☐ Yes ☐ No ☐ Don't Know

2. Have there been any recent changes in your body hair distribution?
   ☐ Yes ☐ No ☐ Don't Know

3. Fluctuating hormone levels can be associated with changes in sexual drive. Have there been recent changes in your sexual desire?
   ☐ Same ☐ More ☐ Less

4. Have you noted any major decrease in the frequency of your erections?
   ☐ Yes ☐ No ☐ Don't Know

5. Do you have any other erectile dysfunction?
   ☐ Yes ☐ No ☐ Don't Know

6. Have you ever fathered a child?
   ☐ Yes ☐ No ☐ Don't Know

7. Have you ever tried but been unable to father a child?
   ☐ Yes ☐ No ☐ Don't Know
   a. If yes, have you ever been tested for infertility?
      ☐ Yes ☐ No ☐ Don't Know
      i. If yes, were you or your partner diagnosed with infertility?
         ☐ Yes, I was ☐ Yes, my partner was ☐ No
         ☐ Other
      ii. Have you ever had infertility treatment?
         ☐ Yes ☐ No

8. Have you ever taken testosterone, DHEA, or other male hormone supplements?
   ☐ Yes
   Which one(s)? For how long?
   ☐ Yes, I have used them, but I don't use them currently.
   Which one(s)? For how long?
   ☐ No, I have never used them.

9. Have you ever taken Viagra?
   - ☐ Yes I take it now
     For how long have you been taking it?
   - ☐ Yes, I've taken it in the past, but haven't recently taken it.
     For how long did you take it?
   - ☐ No, I have never taken it.

10. Have you ever tried but been unable to father a child?
    ☐ Yes ☐ No ☐ Don't Know
    a. If yes, have you ever been tested for infertility?
       ☐ Yes ☐ No ☐ Don't Know
       i. If yes, were you or your partner diagnosed with infertility?
          ☐ Yes, I was ☐ Yes, my partner was ☐ No
          ☐ Other
       ii. Have you ever had infertility treatment?
          ☐ Yes ☐ No

11. Have you ever taken testosterone, DHEA, or other male hormone supplements?
    ☐ Yes ☐ No
    If yes, which medication(s) did you use and for how long?

12. Have you ever taken Viagra, Cialis or similar medications?
    ☐ Yes ☐ No
    If yes, how frequently do/did you take it?
    a. Has it affected your headache?
       ☐ Yes ☐ No ☐ Don't Know
       If so, please describe:

VIII. Headache Treatment

1. Have you seen a physician for your headaches?

   ☐ Yes ☐ No ☐ Don't Know

   a. During the past twelve months:

      i. How many times have you visited a physician for your headaches?

      ii. How many headaches have you averaged per month over the last year?

      iii. How many days have you had to curtail your routine activities because of your headache?

      iv. How many times have you visited a hospital emergency room or urgent care center for treatment of your headaches?

      v. How many times have you had to stay in the hospital for at least one night because of your headaches?

2. Have you received an adequate level of support from:

   a. Family: ☐ Yes ☐ No ☐ Sometimes ☐ Don't Know

   b. Friends: ☐ Yes ☐ No ☐ Sometimes ☐ Don't Know

   c. Physicians: ☐ Yes ☐ No ☐ Sometimes ☐ Don't Know

   d. Please describe:

3. Please indicate if you have ever used any of the following prescription medications *to prevent* headaches:

- - - - - Medication - - - - -	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Frequency (1x day 2x day, week etc.)	Dosage Taken	Effective? Y = Yes N = No ? = Don't Know	If yes, was improvement 1=mild 2=moderate 3=significant	Adverse Effects (If any)
ANTIDEPRESSANTS								
Amitriptyline (Elavil, Endep)	Y N	Y N				Y ? N		
Nortriptyline (Pamelor, Aventyl)	Y N	Y N				Y ? N		
Desipramine (Pertofran, Norpramine)	Y N	Y N				Y ? N		
Fluoxetine (Prozac)	Y N	Y N				Y ? N		
Sertraline (Zoloft)	Y N	Y N				Y ? N		
Paroxetine (Paxil)	Y N	Y N				Y ? N		
Milnacipran (Savella)	Y N	Y N				Y ? N		
Duloxetine (Cymbalta)	Y N	Y N				Y ? N		

- - - - - Medication - - - - -	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Frequency (1x day 2x day, week etc.)	Dosage Taken:	Effective? Y = Yes N = No ? = Don't Know	If yes, was improvement 1=mild 2=moderate 3=significant	Adverse Effects (If any)
NSAIDS								
Ibuprofen (Motrin)	Y N	Y N				Y ? N		
Ketoprofen (Orudis)	Y N	Y N				Y ? N		
Indomethacin (Indocin)	Y N	Y N				Y ? N		
Diclofenac/Misoprostol (Arthrotec	Y N	Y N				Y ? N		
Ketorolac (Toradol)	Y N	Y N				Y ? N		

- - - - - Medication - - - - -	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Frequency (1x day 2x day, week etc.)	Dosage Taken:	Effective? Y = Yes N = No ? = Don't Know	If yes, was improvement 1=mild 2=moderate 3=significant	Adverse Effects (If any)
B-BLOCKERS								
Propranolol (Inderal)	Y N	Y N				Y ? N		
Nadolol (Corgard)	Y N	Y N				Y ? N		
Atenolol (Tenormin)	Y N	Y N				Y ? N		

- - - - - Medication - - - - -	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Frequency (1x day 2x day, week etc.)	Dosage Taken:	Effective? Y = Yes N = No ? = Don't Know	If yes, was improvement 1=mild 2=moderate 3=significant	Adverse Effects (If any)
Other Blood Pressure Medicines								
Verapamil (Calan, Isoptin, Verelan)	Y N	Y N				Y ? N		
Diltiazem (Cardiazem)	Y N	Y N				Y ? N		
Nifedipine (Procardia)	Y N	Y N				Y ? N		
Candesartan (Atacand)	Y N	Y N				Y ? N		
Lisinopril (Zestril, Prinivil)	Y N	Y N				Y ? N		
Clonidine (Catapres)	Y N	Y N				Y ? N		

- - - - - Medication - - - - -	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Frequency (1x day 2x day, week etc.)	Dosage Taken:	Effective? Y = Yes N = No ? = Don't Know	If yes, was improvement 1=mild 2=moderate 3=significant	Adverse Effects (If any)
ANTICONVULSANTS								
Valproic Acid (Depakote, Depakene)	Y N	Y N				Y ? N		
Topiramate (Topamax)	Y N	Y N				Y ? N		
Lamotrigine (Lamictal)	Y N	Y N				Y ? N		
Levetiracetam (Keppra)	Y N	Y N				Y ? N		
Pregabalin (Lyrica)	Y N	Y N				Y ? N		
Gabapentin (Neurontin)	Y N	Y N				Y ? N		
Zonisamide (Zonegran)	Y N	Y N				Y ? N		

- - - - - Medication - - - - -	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Frequency (1x day 2x day, week etc.)	Dosage Taken:	Effective? Y = Yes N = No ? = Don't Know	If yes, was improvement 1=mild 2=moderate 3=significant	Adverse Effects (If any)
ANTISEROTONIN								
Methysergide (Sansert)	Y N	Y N				Y ? N		

- - - - - Medication - - - - -	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Frequency (1x day 2x day, week etc.)	Dosage Taken:	Effective? Y = Yes N = No ? = Don't Know	If yes, was improvement 1=mild 2=moderate 3=significant	Adverse Effects (If any)
NARCOTICS								
Methadone (Dolophine)	Y N	Y N				Y ? N		
Fentanyl (Duragesic, Actiq)	Y N	Y N				Y ? N		
Morpine (MS Contin)	Y N	Y N				Y ? N		

- - - - - Medication - - - - -	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Frequency (1x day 2x day, week etc.)	Dosage Taken:	Effective? Y = Yes N = No ? = Don't Know	If yes, was improvement 1=mild 2=moderate 3=significant	Adverse Effects (If any)
BENZODIAZEPINES								
Lorazepam (Ativan)	Y N	Y N				Y ? N		
Alprazolam (Xanax)	Y N	Y N				Y ? N		
Clonazepam (Klonopin)	Y N	Y N				Y ? N		

- - - - - Medication - - - - -	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Frequency (1x day 2x day, week etc.)	Dosage Taken:	Effective? Y = Yes N = No ? = Don't Know	If yes, was improvement 1=mild 2=moderate 3=significant	Adverse Effects (If any)
OTHERS:								
Olanzapine (Zyprexa)	Y N	Y N				Y ? N		
Quetiapine (Seroquel)	Y N	Y N				Y ? N		
Ziprasidone (Geodon)	Y N	Y N				Y ? N		
Risperodone (Risperdal)	Y N	Y N				Y ? N		
Cyproheptadine (Periactin)	Y N	Y N				Y ? N		
Diphenhydramine (Benadryl)	Y N	Y N				Y ? N		

4. Please indicate if you have ever used any of the following prescription medications *to relieve* a headache:

- - - - - Medication - - - - -	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Frequency (1x day 2x day, week etc.)	Dosage Taken:	Effective? Y = Yes N = No ? = Don't Know	If yes, was improvement 1=mild 2=moderate 3=significant	Adverse Effects (If any)
TRIPTANS								
Sumatriptin (Imitrex)	Y N	Y N				Y ? N		
Rizatriptan (Maxalt)	Y N	Y N				Y ? N		
Naratriptan (Amerge)	Y N	Y N				Y ? N		
Ergotamine (Ergostat, Cafergot, etc.)	Y N	Y N				Y ? N		
Frovatriptan (Frova)	Y N	Y N				Y ? N		
Zolmatriptan (Zomig)	Y N	Y N				Y ? N		
Sumatriptan/Naproxen (Treximet)	Y N	Y N				Y ? N		
Almotriptan (Axert)	Y N	Y N				Y ? N		
Ergotamine (Ergostat, Cafergot, DHE.)	Y N	Y N				Y ? N		

- - - - - Medication - - - - -	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Freque ncy (1x day 2x day, week etc.)	Dosage Taken:	Effective? Y = Yes N = No ? = Don't Know	If yes, was improvemen t 1=mild 2=moderate 3=significant	Adverse Effects (If any)
NSAIDS								
Ibuprofen (Motrin)	Y N	Y N				Y ? N		
Ketoprofen (Orudis)	Y N	Y N				Y ? N		
Naproxen (Naprosyn, Anaprox)	Y N	Y N				Y ? N		
Ketorolac (Toradol)	Y N	Y N				Y ? N		
Diclofenac/Misoprostol (Arthrotec	Y N	Y N				Y ? N		
Isometheptene Midrin)	Y N	Y N				Y ? N		

- - - - - Medication - - - - -	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Frequency (1x day 2x day, week etc.)	Dosage Taken:	Effective? Y = Yes N = No ? = Don't Know	If yes, was improvement 1=mild 2=moderate 3=significant	Adverse Effects (If any)
NARCOTICS								
Tylenol and Codeine (Tylenol #3)	Y N	Y N				Y ? N		
Hydrocodone (Lorcet, Hydrocet)	Y N	Y N				Y ? N		
Oxycodone (Percocet,Roxicet,Tylox)	Y N	Y N				Y ? N		
Meperidine (Demerol)	Y N	Y N				Y ? N		
Fentanyl (Actiq)	Y N	Y N				Y ? N		
Butorphanol (Stadol)	Y N	Y N				Y ? N		

- - - - - Medication - - - - -	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Frequency (1x day 2x day, week etc.)	Dosage Taken:	Effective? Y = Yes N = No ? = Don't Know	If yes, was improvement 1=mild 2=moderate 3=significant	Adverse Effects (If any)
OTHERS								
Butalbital products (Fioricet, Esgic, Isocet, Phrenilin, etc.)	Y N	Y N				Y ? N		
Chlorpromazine (Thorazine)	Y N	Y N				Y ? N		
Procholoperazine (Compazine)	Y N	Y N				Y ? N		

5. Please list any over-the-counter medication, vitamins, herbs and homeopathic remedies you have used for your headaches:

Medication, vitamin, herb or homeopathic remedy:	Ever Used?	Still Use?	For how long did you take it? (m/yy – m/yy)	Dosage Taken:	Frequency (1 x day 2 x day, week etc.)	Effective?	If yes, was Improvement 1=mild 2=moderate 3=significant	Adverse Effects (If any)
	Y N	Y N				Y ? N		
	Y N	Y N				Y ? N		
	Y N	Y N				Y ? N		
	Y N	Y N				Y ? N		
	Y N	Y N				Y ? N		
	Y N	Y N				Y ? N		
	Y N	Y N				Y ? N		
	Y N	Y N				Y ? N		
	Y N	Y N				Y ? N		
	Y N	Y N				Y ? N		
	Y N	Y N				Y ? N		
	Y N	Y N				Y ? N		
	Y N	Y N				Y ? N		

6. In addition to the above medications, which of the following have you used for treatment of your headaches?

Therapy	Never Used	Presently Using	Tried in the Past	Effect on Headache Worse/Improved/ Unchanged/Don't Know
Acupuncture				
Biofeedback				
Aromatherapy				
Chiropractic Treatment				
Relaxation Therapy				
Cognitive Therapy/Psychotherapy				
Reflexology				
Massage				
Avoidance of foods and/or drinks that trigger headache				
Avoidance of activities that trigger headache				
Other:				
Other:				
Other:				
Other:				