HEADACHE HISTORY

NAME _____ **TODAY'S DATE** _____
PRESENT AGE _____ **SEX** _____

BEGAN:

1. Headaches started _____ years ago
Age at onset:
_____ under 20; _____ 20–30; _____ 31–50; _____ over 50 years old

CAUSE:

2. ___ Injury: type _____
_____ Date of injury: _____

_____ no injury; _____ infection; _____ pregnancy; _____ emotional stress;
_____ other: _____

FREQUENCY:

3. Headaches occur _____ times each _____ (day, week, month)
Are they increasing? _____ Yes _____ No

LOCATION: _____

_____

4. Starts _____ left side; _____ right side; _____ either side; _____ all over head (hatband); _____ face/jaw; _____ other: _____

5. _____ usually stays in one place; _____ sometimes moves around; _____ often moves around; If they move around, please explain: _____

_____

DURATION:

6. Lasts _____ if not treated; _____ if treated immediately; _____ if treated after they are severe

7. Free of headaches from _____ to _____
_____ Never been free of headaches

PRECIPITATING FACTORS:

8. Headache can be brought on by:
_____ fatigue; _____ stress/tension; _____ oversleeping; _____ certain foods; _____ alcohol; _____ certain medications; _____ menstruation; _____ coughing; _____ shaving or touching face; _____ washing; _____ chewing; _____ talking; _____ lying down; _____ stooping; _____ exercise; _____ other: _____

HORMONAL:

(WOMEN ONLY)

9. **a:** Headaches affected by menstrual cycle (how?) _____
b: Headaches affected by pregnancy (how?) _____

SEASONALITY:

10. More frequent in _____ spring; _____ summer; _____ fall; _____ winter; _____ not seasonal

PRODROMATA:

11. Warnings before headaches:
_____ halos around eyes; _____ blind spots; _____ upset stomach; _____ feeling of tightness around head; _____ flashing lights; _____ dizziness; _____ light-headed; _____ numbness in leg or arm; _____ other: _____

PAIN TYPE:

12. Pain is _____ throbbing; _____ dull; _____ sharp; _____ tight band; _____ stabbing; _____ burning; other: _____

SEVERITY:

13. Pain is _____ mild to moderate; _____ severe; _____ very severe; _____ unbearable

14. Headache prevents normal activities such as work. _____ Yes _____ No

FAMILY HISTORY:

15. Relatives with headaches: _____

ASSOCIATED SYMPTOMS:

16. Symptoms accompanying headache:

_____ nausea and vomiting; _____ insomnia; _____ frequent and/or early awakening; _____ light sensitivity; _____ sound sensitivity; _____ tinnitus; _____ eye tearing; _____ visual disturbance; _____ nasal congestion; _____ dizziness; _____ paresthesia; _____ stiff neck; _____ other: _____

PREVIOUS CARE:

17. Other doctors seen for headache treatment? _____

18. What tests/x-rays because of headaches? _____

19. Medications taken for headaches: _____

20. Other treatments, such as biofeedback, for headaches? _____

21. Medical history

_____ asthma; _____ cancer/tumor; _____ diabetes; _____ epilepsy; _____ eye problems; _____ allergies; _____ head injury; _____ hearing problems; _____ heart trouble; _____ high blood pressure; _____ kidney/liver disease; _____ nervous breakdown; _____ sinusitis; _____ stomach/duodenal ulcer

22. Current medications, other than those for headaches: _____

23. Allergic to medications? _____

24. Allergic to foods? _____ cheese; _____ chocolate; _____ cola drinks; _____ nuts; _____ MSG (monosodium glutamate); _____ spicy foods; _____ other: _____

25. Hospitalization (for other than normal pregnancy): _____

26. Drinks alcoholic beverages? _____ Yes _____ No
Average daily consumption: _____

27. Tobacco use _____ Yes _____ No Average per day: _____

28. History of fainting _____ ; seizures _____

29. Problems with ears or eyesight: _____

30. History of drug abuse? _____ prescribed _____; nonprescribed _____

31. WOMEN ONLY
Number of pregnancies: _____
Number of children born alive: _____

32. Additional general health comments: _____