Baylor Scott & White
NEUROLOGY
MCKINNEY

Headache Questionnaire

When did the headaches first begin?_____
How often do they occur? _____
Do the headaches occur at a certain time of day?_____
Are the headaches constant, or do they come and go? _____
Have the headaches changed in (circle any): Severity / Duration / Frequency?
If changed, how?_____
Is the headache worse with position (circle one): Laying / Standing / Not effected

What part of your head hurts?_____
What does the pain feel like?_____
Do the headaches stop you from any daily or social activities? no yes, If yes, please list: _____
Are there any warning signs before the headache begins? no yes, If yes, please list: _____

Do the headaches ever wake you up while sleeping? no yes
Does rest or sleep relieve the headaches? no yes
Are nasal congestion, sinusitis or allergies associated with the headache? no yes
Any Nausea or vomiting with the headaches? no yes
Any Sensitivity to light with the headaches? no yes
Any pain with neck movements? no yes
What Headache Medications have you tried in the past and why were they stopped?

_____ _____

_____ _____

Do you have any triggers that bring on a headache**:** no yes, if yes check them:

_____Odors (Perfume, cigarettes)
_____Hunger (missing meals)
_____Exercise or playing
_____Too much sleep (sleeping in)
_____Too little sleep (staying up late)
_____Riding in a car
_____Fatigue
_____Loud noises
_____Ice Cream
_____Bright Lights
_____Sunshine
_____Hot weather
_____School
_____Anxiety or stress
_____Family problems
_____Menstrual cycles
_____Birth Control Pills
_____Alcohol
_____Medications, Which ones?_____
_____Certain foods, Which ones?_____
_____Other triggers: _____

Have you had other therapies? If so, please list:
_____
_____

Name: DOB: Date