HEADACHE FOLLOW-UP VISIT (PATIENT)

Date of Last Office Visit for Headache
(_______/_______/_______)

Last Menstrual Period _____________________

Could you be pregnant?  □ yes  □ no

Using Contraception?  □ yes  □ no

INSTRUCTIONS:
Please answer the following questions about all of your headaches over the last 3 months. Write your answer on the line next to each question. Write zero if you did not do the activity in the last 3 months (USE NUMBERS ONLY)

1. 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 in the box.)  _____________________ DAYS

2. 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 work or school, enter zero.)  _____________________ DAYS

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

4. 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 question 3, where you did not do housework.)  _____________________ DAYS

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

Questions 1-5  TOTAL

On average how many days per month do you have any headache?  _____________________ DAYS

On average how many days per month do you have a severe headache?  _____________________ DAYS

On average how many days per month did you treat a headache with medication (including over-the-counter)?  _____________________ DAYS

(NOTE: if the headache lasted more than 1 day, count each day)

PLEASE COMPLETE QUESTIONS ON REVERSE SIDE
# of Emergency Room/Urgent Care visits for headache treatment since last seen: ______________________________

SINCE YOUR LAST OFFICE VISIT:

- Headache Frequency (please circle): Same, More Frequent, Less Frequent
- Headache Severity (please circle): Same, More Severe, Less Severe

Has there been any significant change in the character or quality of your headaches since last seen?
- No, Yes
  If Yes, ____________________________________________________________________________________

How often do you have nausea with your headaches? 0%, 25%, 50%, 75%, 100%

What is the average time from start of your headache to its peak intensity? (Minutes/Hours): _______________

On average, what percentage of time does the headache wake you up? 0%, 25%, 50%, 75%, 100%

Sleeping Pattern: Good, Fair, Poor
  On average how many restful nights of sleep do you get per week? ______

Have you used over the counter (OTC) medications in the past 2 weeks? Yes, No
  If yes, what is the average number of days/week that OTC medications are used? ____________________________
  Which OTC medications? _____________________________________________________________________________________

HEADACHE TREATMENT OPTIMIZATION QUESTIONNAIRE:

Base your answer on your experience of the last 4 weeks:
  Can you quickly return to normal activities after taking your migraine medication? Yes, No
  Can you usually count on your migraine medication to relieve pain within 2 hours? Yes, No
  Does one dose of medication usually relieve your headache and keep it away for at least 24 hours? Yes, No
  Is your migraine medication well tolerated? Yes, No
  Are you comfortable enough with your medication to plan your daily activities? Yes, No

(Used with permission from Richard Lipton, MD)

Women: Do you understand that you need to inform me if you become pregnant or begin breastfeeding?
- Yes, No

How satisfied are you with your current headache treatment? Not at all, Somewhat, Very

Other Questions/Would you like more information on a particular headache related topic? ____________________________

THANKS FOR CHOOSING DEAN FOR YOUR HEALTH CARE