

## Patient Questionnaire – Headache Evaluation

Dear Patient,

In order to fully evaluate your headache condition, I would like you to fill out his headache survey before we meet in the office. Please bring this with you to your appointment.

1. **Is there primarily one type or more than one type of headache?** \_\_\_\_\_

If you have more than one type, answer the following questions as they pertain to the most severe headache type.

2. **When did the headaches begin? (age of onset)** \_\_\_\_\_

3. **If you have had headaches for years, what were they like in the beginning (frequency, location, severity, etc.)?**  
\_\_\_\_\_

4. **What time of day does the headache occur most often?** \_\_\_\_\_

Do your headaches usually occur on a specific day of the week? \_\_\_\_\_

5. **Where are the headaches located? (Check all that apply)**

Neck    Behind the eye    Back of the head    Temples    Forehead    Top of the head

Are your headaches generally    On one side?    On both sides?

If one-sided, are they always on the same side? \_\_\_\_\_

If both-sided, do they usually start on one side? \_\_\_\_\_

6. **How often do the attacks occur?**    Daily    Weekly    Monthly

If daily, how long have they occurred on a daily basis? \_\_\_\_\_

How many severe headaches per month? \_\_\_\_\_

Have they recently changed in frequency and/or severity? \_\_\_\_\_

7. **Does stress make your headaches worse?** \_\_\_\_\_

Do you tend to have more (or less) headaches on weekends/vacations (i.e., less stressful times)?  
\_\_\_\_\_

8. **If untreated, how long do they last?**    Minutes    Hours    Days

On average, how long does it take for your headaches to reach their peak intensity?

Minutes    Hours    Other \_\_\_\_\_ Do your headaches frequently awaken you? \_\_\_\_\_

9. **Please describe the pain. (Check all that apply).**

Pulsating    Throbbing    Pounding    Squeezing    Vice-Like    Tightening

Pressing    Dull    Constricting    Stabbing    Shock-Like    Other \_\_\_\_\_

10. **Please rate the range of severity of your headaches where 0 is no pain and 10 is the worst pain that you have ever experienced.** Least severe headache \_\_\_\_\_ Worst headache \_\_\_\_\_

11. Do you feel any different one to two days before your headache occurs (e.g., euphoria, irritable, hyperactive, depressed, agitated, anxious)? \_\_\_\_\_

Do you crave certain foods before the headache comes on? \_\_\_\_\_

12. Do you have warning signs that the headache is soon to occur (an aura)?

Do you experience: (Check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> visual zigzag lines                | <input type="checkbox"/> excessive yawning                                  | <input type="checkbox"/> blurred vision         |
| <input type="checkbox"/> blackened portions of visual field | <input type="checkbox"/> distorted visual shapes                            | <input type="checkbox"/> difficulty with speech |
| <input type="checkbox"/> one-sided visual loss              | <input type="checkbox"/> one-sided numbness, tingling                       | <input type="checkbox"/> neck pain              |
| <input type="checkbox"/> disturbance in sense of smell      | <input type="checkbox"/> flashing or shimmering lights in your visual field |   |

Do the aura symptoms usually stop before the headache begins? \_\_\_\_\_

How soon do the headaches come on after the aura is finished? \_\_\_\_\_

13. During the headaches, are there any associated symptoms? (Check all that apply)

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> room spinning     | <input type="checkbox"/> sensitivity to bright lights | <input type="checkbox"/> sensitivity to sounds and/or odors |                                       |
| <input type="checkbox"/> nausea            | <input type="checkbox"/> vomiting                     | <input type="checkbox"/> dizziness                          | <input type="checkbox"/> unsteadiness |
| <input type="checkbox"/> numbness/tingling | <input type="checkbox"/> difficulty with speech       | <input type="checkbox"/> other _____                        |                                       |

14. Sleep Habits: Are you a good sleeper? \_\_\_\_\_ If no, do you have problems falling asleep, staying asleep or both? \_\_\_\_\_

How many nights of good, restful sleep do you get per week? \_\_\_\_\_

When you have a severe headache, will sleep usually relieve the headache? \_\_\_\_\_

15. Does anything in particular bring on the headache? (Check all that apply)

- |   |   |   |  |  |
|---|---|---|--|--|
| <input type="checkbox"/> exercise                 | <input type="checkbox"/> sexual relations/orgasm        | <input type="checkbox"/> stress                   | <input type="checkbox"/> menstrual periods | <input type="checkbox"/> certain foods |
| <input type="checkbox"/> certain odors            | <input type="checkbox"/> coughing                       | <input type="checkbox"/> sneezing                 | <input type="checkbox"/> weather changes   | <input type="checkbox"/> lack of sleep |
| <input type="checkbox"/> caffeine                 | <input type="checkbox"/> glare/bright lights            | <input type="checkbox"/> high humidity            | <input type="checkbox"/> change of seasons |  |
| <input type="checkbox"/> strobe/flickering lights | <input type="checkbox"/> fast action movies/video games | <input type="checkbox"/> certain types of alcohol |  |  |
| <input type="checkbox"/> fatigue                  | <input type="checkbox"/> prolonged hunger               | <input type="checkbox"/> having a bowel movement  | <input type="checkbox"/> other _____       |  |

Does walking up stairs or similar routine physical activity worsen the headache? \_\_\_\_\_

Do you avoid movement of even a mild nature (head movement or bending down) during an attack? \_\_\_\_\_

Are your headaches better or worse in a certain position? \_\_\_\_\_

16. Habits: Do you smoke cigarettes? \_\_\_\_\_ If so, how much and for how many years? \_\_\_\_\_

How much alcohol do you drink in a week's time? \_\_\_\_\_

How many cups of caffeinated coffee, tea or cola do you drink each day? \_\_\_\_\_

17. What is your occupation? \_\_\_\_\_

Have you ever had to take off work/school or alter your activities of daily living because of headaches? \_\_\_\_\_

How many days of work/school per month on average do you miss because of headaches? \_\_\_\_\_

How many days of work/school per month do you report with a headache but are significantly less effective than usual? \_\_\_\_\_

**18. Other Conditions: Have you ever been diagnosed with: (Check all that apply)**

- manic depressive (bipolar) disorder     anxiety     panic attacks     seizures     depression  
 Raynaud's phenomenon     physical/sexual abuse     obstructive sleep apnea  
 post traumatic stress disorder     vertigo/dizziness

Are you currently being treated for any of these conditions? \_\_\_\_\_

**19. Do "sick" headaches or migraines run in your family (mom, sister, etc.)?** \_\_\_\_\_

Do you remember anyone in your family having to come home from work/school regularly because of severe headaches? \_\_\_\_\_

**20. WOMEN: At what age did you first begin menstruating?** \_\_\_\_\_

Are your headaches related to your periods or ovulation? \_\_\_\_\_

If so, when do they occur in relation to your period (before, during, or after)? \_\_\_\_\_

Are your periods regular? \_\_\_\_\_

Have you ever been pregnant? \_\_\_\_\_

Did your headaches change during pregnancy? \_\_\_\_\_

Do you take birth control pills or other female hormones? \_\_\_\_\_

If so, which one(s) and for how long? \_\_\_\_\_

**21. Do you take pain medications (prescription or non-prescription) on a daily or near daily basis?**

What do you take to treat the pain? \_\_\_\_\_

How many days of the week do you take something for your headache? \_\_\_\_\_

List all the over-the-counter pills you have taken in the past four weeks (pain pills, herbs, vitamins, etc.):

\_\_\_\_\_  
\_\_\_\_\_

**22. Childhood Migraine Equivalents: Did you have significant motion (car) sickness in childhood?** \_\_\_\_\_

Did you have intermittent episodes of significant nausea/vomiting and/or abdominal pain in childhood? \_\_\_\_\_

**23. Trauma/Injuries: Have you ever been knocked out or suffered a serious head injury?** \_\_\_\_\_

If yes, when? \_\_\_\_\_ Did you have headaches after the injury? \_\_\_\_\_

Have you ever had a motor vehicle (car) accident? \_\_\_\_\_ When? \_\_\_\_\_

Any injuries? \_\_\_\_\_

Have you ever had a whiplash, roller coaster or carnival ride-type injury? \_\_\_\_\_

**24. Have you ever been treated for your headaches before?** \_\_\_\_\_

By whom? \_\_\_\_\_ Have you ever seen a neurologist for your headaches? \_\_\_\_\_

Who did you see? \_\_\_\_\_ When \_\_\_\_\_ Are you still seeing him/her? \_\_\_\_\_

**25. What tests have been done to evaluate your headaches?**

CT scan of the head    Where? \_\_\_\_\_    When? \_\_\_\_\_

MRI of the head    Where? \_\_\_\_\_    When? \_\_\_\_\_

Spinal tap    Where? \_\_\_\_\_    When? \_\_\_\_\_

*CONTINUED ON OTHER SIDE*

## Previous Medications and Treatments

Please use the following abbreviations:

E = medication/treatment taken and effective

NE = medication/treatment taken and not effective

NT = medication treatment taken and not tolerated

### Preventive

(If more than one medication is listed, please circle whichever med was taken)

\_\_\_\_\_ Inderal (propranolol)/Corgard (nadolol)/  
Tenormin (atenolol)

\_\_\_\_\_ Topamax (topiramate)

\_\_\_\_\_ Neurontin (gabapentin)

\_\_\_\_\_ Elavil (amitriptyline)/Pamelor (nortriptyline)/  
Tofranil (imipramine)

\_\_\_\_\_ Vitamin B2 (riboflavin)/Magnesium/Feverfew

\_\_\_\_\_ Coenzyme Q10

\_\_\_\_\_ Calan/Isoptin/Verelan (verapamil)

\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Depakote (valproic acid)

### Abortive

(If more than one medication is listed, please circle whichever med was taken)

\_\_\_\_\_ Aspirin

\_\_\_\_\_ Stadol nasal spray

\_\_\_\_\_ Tylenol (acetaminophen)

\_\_\_\_\_ Imitrex pills/Zomig pills/Amerge pills/

Maxalt pills/Axert pills/Frova pills/Relpax pills

\_\_\_\_\_ Excedrin/Anacin/Vanquish

\_\_\_\_\_ Imitrex injection/nasal spray/Zomig nasal spray

\_\_\_\_\_ Ibuprofen/Advil/Naproxen/Aleve

\_\_\_\_\_ Migranal (DHE) nasal spray

\_\_\_\_\_ Fiorinal/Fioricet/Esgic

\_\_\_\_\_ Prednisone

\_\_\_\_\_ Cafergot/Ergostat/Wigraine

\_\_\_\_\_ Oxygen

\_\_\_\_\_ Midrin (isometheptene/dichloralphenazone/APAP)

\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Demerol/Tylenol with codeine/

Vicodin (hydrocodone)/Percocet (oxycodone)

### Other

\_\_\_\_\_ Acupuncture/Acupressure

\_\_\_\_\_ Cranial sacral therapy

\_\_\_\_\_ Chiropractic

\_\_\_\_\_ Nerve blocks

\_\_\_\_\_ Physical therapy/Massage therapy

\_\_\_\_\_ Ice/cold compresses

\_\_\_\_\_ Stress reduction/Yoga/Meditation/Biofeedback

\_\_\_\_\_ Other \_\_\_\_\_

What are your goals for treatment? \_\_\_\_\_

Do you have any other questions regarding headaches? \_\_\_\_\_



East Clinic  
1821 S. Stoughton Road  
Madison, WI 53716

## PATIENT HISTORY

Dear Patient:

Welcome to Dean East Clinic. Please take a moment to fill out this medical history form so that your physician can get better acquainted with your medical history. We realize that not all of the questions may pertain to you, but please answer all questions that apply. Thank you.

If you are new to this clinic, who was your previous primary care physician? \_\_\_\_\_

### PAST MEDICAL HISTORY:

1. Please list any active medical problems for which you are currently being treated, such as hypertension, diabetes, high cholesterol, asthma, seizures.

\_\_\_\_\_

2. Please list your surgeries with the date(s) \_\_\_\_\_

\_\_\_\_\_

3. Please list your non-surgical hospitalizations with the date(s)

\_\_\_\_\_

4. Please list any major accidents or injuries with the date(s) \_\_\_\_\_

\_\_\_\_\_

### PREVENTIVE INFORMATION

Have you ever had (and date):

Flu Vaccine \_\_\_\_\_ Hepatitis-B Vaccine \_\_\_\_\_

Pneumonia Vaccine \_\_\_\_\_ Tetanus Vaccine \_\_\_\_\_

Do you use seat belts?  Always  Sometimes  Never

Do you have smoke detectors in your home/apartment?  Yes  No

Do you have a loaded firearm in your home/apartment?  Yes  No

If yes, how is it stored? \_\_\_\_\_

(Note: this question is only intended to raise awareness about safe storage of firearms)

**WOMEN:** When was your last:

Pap smear \_\_\_\_\_ Mammogram \_\_\_\_\_

Bone density study \_\_\_\_\_ Do you perform self breast exams regularly?  Yes  No

### SOCIAL HISTORY / LIFESTYLE:

Where were you born and raised? \_\_\_\_\_ How long have you been in this area? \_\_\_\_\_

Do you still drive an automobile?  Yes  No

Marital status? (Please check)  Single  Married  Widowed  Divorced  Separated

Who lives at home with you? \_\_\_\_\_

Occupation? \_\_\_\_\_ Your hobbies? \_\_\_\_\_

– Please continue on reverse side –

## PATIENT PHYSICAL HISTORY (Page 2)

### SOCIAL HISTORY / LIFESTYLE (continued):

Do you ride a motorcycle / bicycle?  Yes  No  
If yes, do you wear a helmet?  Always  Sometimes  Never

Do you smoke or use nicotine products?  Yes  No How many years? \_\_\_\_\_  
 Cigarettes (# Packs / day) \_\_\_\_\_  Cigars  Pipe  Chew tobacco

Have you ever used recreational drugs?  Yes  No  
If yes, when was the last time? \_\_\_\_\_ What kind did you use? \_\_\_\_\_

Do you take over-the-counter medication (such as aspirin, antacids, vitamins, herbal products, cold preparations) more than once a week?  Yes  No; If yes, which ones and how often? \_\_\_\_\_

Do you take calcium supplements?  Yes  No; How many servings of milk, cheese, cottage cheese, yogurt or calcium-fortified orange juice do you consume daily? \_\_\_\_\_

Do you take something to help you sleep more than once a week?  Yes  No \_\_\_\_\_

Do you restrict your diet in any way? (such as low calorie, low fat, no added salt, etc.?)  Yes  No \_\_\_\_\_

### FAMILY HISTORY:

How many children do you have?  None Sons \_\_\_\_\_ Daughters \_\_\_\_\_

Are all alive and in good health?  Yes  No; If no, please explain: \_\_\_\_\_

How many siblings do you have?  None Brothers \_\_\_\_\_ Sisters \_\_\_\_\_

Are they alive and well?  Yes  No  
If no, please explain: \_\_\_\_\_

Is your mother still living?  Yes  No;  
If yes, major health problems / If no, cause of death \_\_\_\_\_

Is your father still living?  Yes  No  
If yes, major health problems / If no, cause of death \_\_\_\_\_

Is there a family history (father mother, sister, brother, or children) of:

- Diabetes  Depression
- High Cholesterol  Suicide
- Heart Attacks before age 65  Alcoholism / Drug Abuse
- Cancer (Prostate, Skin, Breast, Colon, Ovarian)

### SYSTEMS REVIEW:

#### GENERAL – Have you noticed:

Significant weight change ( > 10#) in the past 6 months? If yes,  Increase  Decrease

Significant recent appetite change? If yes,  Increase  Decrease

Significant sweating or night sweats?  Yes  No

#### SKIN – Have you had:

Recent rashes, lumps, or other skin / hair / nail problems?  Yes  No

A history of skin cancer?  Yes  No

# PATIENT PHYSICAL HISTORY (Page 3)

## SYSTEMS REVIEW (continued):

### EYES – Have you had:

Recent vision changes?  Yes  No Last eye appointment: \_\_\_\_\_ With whom? \_\_\_\_\_  
Glaucoma/Cataracts?  Yes  No

### EARS / NOSE / MOUTH / THROAT – Have you had:

Hearing Problems?  Yes  No; Do you have / use hearing aides?  Yes  No

Frequent wax impaction?  Yes  No

Frequent nosebleeds?  Yes  No

Do you have a history of Obstructive Sleep Apnea?  Yes  No If yes, do you use CPAP? \_\_\_\_\_

Do you snore so loudly that your bed partner complains about it?  Yes  No

Do you have excessive daytime fatigue?  Yes  No

Do you notice SIGNIFICANT dizziness, vertigo?  Yes  No

## CARDIOVASCULAR

Do you get:

Chest pain / pressure / tightness / squeezing?  Yes  No

If yes, does it occur with activity or exertion?  Yes  No

Heart fluttering / flip-flops / skipping or palpitations?  Yes  No

Swelling of ankles?  Yes  No

Pain in legs while walking?  Yes  No

How far can you walk before you get short of breath?  Feet  Blocks  Miles  Unlimited

Do you take antibiotics before dental work?  Yes  No

Do you exercise on a regular basis (more than 2x per week)?  Yes  No

If yes, what type of exercise? \_\_\_\_\_ How often? \_\_\_\_\_

## RESPIRATORY – Have you ever been told that you have:

Asthma?  Yes  No

Emphysema/chronic bronchitis?  Yes  No

Blood clots in your leg or lung?  Yes  No

Tuberculosis (TB) or positive TB skin test?  Yes  No

Do you notice **frequent**:

Wheezing / Shortness of breath?  Yes  No

Coughing / Phlegm production?  Yes  No

Coughing up blood?  Yes  No

## GASTROINTESTINAL – Do you notice:

Frequent nausea or vomiting?  Yes  No

Frequent diarrhea?  Yes  No

Significant constipation?  Yes  No

Bloody or black bowel movements?  Yes  No

Frequent heartburn / regurgitation / indigestion?  Yes  No

# PATIENT PHYSICAL HISTORY (Page 4)

## GASTROINTESTINAL (continued):

- Do you take antacids or acid blocking agents more than once/week?  Yes  No  
Trouble swallowing / Food getting stuck?  Yes  No  
Have you ever been diagnosed with:  Ulcers  Hepatitis  Colitis  
**Have you ever had a colonoscopy?**  Yes  No  
If yes, when \_\_\_\_\_

## GENITOURINARY – Do you notice:

- Burning / frequency or hesitation with urination?  Yes  No  
Do you wake up more than 2 times /night to urinate?  Yes  No  
Do you have significant difficulty starting your urine stream?  Yes  No  
Dribbling after urination or problems holding your urine?  Yes  No  
Do you have to wear a pad for incontinence more than once/week?  Yes  No  
Have you ever had kidney stones?  Yes  No  
If yes, when was your last episode? \_\_\_\_\_  
Problems with your sex drive?  Yes  No  
Have you ever had a sexually transmitted disease?  Yes  No  
If yes, what type(s)?  Syphilis  Gonorrhea  Chlamydia  Warts  
Are you sexually active  Yes  No; If yes, with:  Women?  Men?  Both?  
How many sexual partners have you had in the last 6 months? \_\_\_\_\_  
What kind of birth control do you use?  Condoms  Pills  IUD  Diaphragm  
 Tubal ligation  Vasectomy  None  Other \_\_\_\_\_  
Do you use condoms?  Always  Most of the time  Rarely  Never  
Have you ever been physically or sexually abused?  Yes  No  
Would you like to discuss this further?  Yes  No  
Do you feel safe in your current home/environment?  Yes  No

## WOMEN: – Do you have or have you had:

- Problems related to menopause/change of life?  Yes  No  
An abnormal Pap smear?  Yes  No; If yes, when \_\_\_\_\_  
An abnormal mammogram?  Yes  No; If yes, when \_\_\_\_\_  
Breast discharge, masses, or cancer?  Yes  No

## MEN:

- Do you have difficulty with erections?  Yes  No  
Would you like to discuss this further?  Yes  No

## MUSCULOSKELETAL – Do you have or have you had:

- Significant joint pains or arthritis?  Yes  No If yes, which joints bother you most? \_\_\_\_\_  
Gout?  Yes  No; If yes, last episode \_\_\_\_\_  
Significant neck pain that bothers you most days?  Yes  No  
Significant low back pain that bothers you most days?  Yes  No

# PATIENT PHYSICAL HISTORY (Page 5)

## NEUROLOGICAL – Do you have or have you had:

- Tremors / shakes?  Yes  No
- Significant memory problems?  Yes  No  
If yes, does it interfere with functioning?  Yes  No
- A significant fall in the past year?  Yes  No
- Seizures?  Yes  No
- Significant headaches – severe enough to make you go home from school or work?  Yes  No
- Blackouts / fainting spells?  Yes  No  
If yes, when was your last fainting spell? \_\_\_\_\_
- Significant numbness / tingling noted on a daily basis?  Yes  No  
If yes, where is the numbness/tingling noted? \_\_\_\_\_

## MENTAL / EMOTIONAL

- In the last 2 weeks, have you felt down, depressed, or hopeless?  Yes  No
- Have you recently had little interest or pleasure in doing your day to day activities?  Yes  No
- Have you ever had depression so severe that you considered suicide?  Yes  No
- Do you feel that you worry excessively to the point where you feel your muscles tighten and/or can't sleep?  Yes  No

**Do you drink alcohol?**  Not at all  Occasionally  Daily

If you drink alcohol, on any single occasion in the past 3 months have you had more than 5 drinks containing alcohol?  Yes  No

**If yes:** On how many days per week do you drink alcohol? \_\_\_\_\_

On a typical day when you drink, how many drinks do you have? \_\_\_\_\_

What is the maximum number of drinks that you had on any given day in the past month? \_\_\_\_\_

Have you seen a psychiatrist or therapist in the past?  Yes  No

When were you last seen? \_\_\_\_\_ By whom \_\_\_\_\_

## HEMATOLOGIC / LYMPHATIC & ALLERGIC / IMMUNOLOGIC – Have you had:

- Anemia?  Yes  No
- Problems with your spleen or had your spleen removed?  Yes  No
- Bleeding or clotting problems?  Yes  No
- Easy bruising?  Yes  No

Do you have:

Seasonal allergies/hay fever?  Yes  No

If yes, do you take something for this? \_\_\_\_\_

Food, latex or drug allergies?  Yes  No

If yes, from what food and/or drug with what type of reaction? \_\_\_\_\_

Have you ever seen an allergist  Yes  No

## SOCIAL:

- Do you have a Durable Power of Attorney (DPA) for Health Care, Living Will or other Advanced Directives?  Yes  No  
Would you like information regarding this?  Yes  No
- Do you have any other questions or would you like any information about a specific health related topic?  
\_\_\_\_\_  
\_\_\_\_\_

*Thank you for taking the time to complete this questionnaire. It helps us provide the best possible health care for you.*