**Cumberland Neurology Group**
**Headache History Form**

Name ______________________________ Date of Birth_________ Date Completed________________

Please complete this form in addition to the medical history form prior to your first visit.

1. At what age did you have your first significant headache? __________________
2. Do remember the specific date your headaches started? _____ Yes _______Date _____No
3. Cause (trigger) of first headache:
   - ______ None known
   - ______ Injury
   - ______ Menstrual period
   - ______ Pregnancy
   - ______ Other____________________

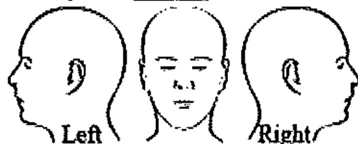
4. Have your headaches progressed (gotten worse) since they first started? ________Yes ________No
   If yes:
   When did they start to progress?____________________
   Frequency of headaches <u>before</u> they started to progress: _____days per _____week _____month ____year
   Severity of headaches <u>before</u> they started to progress (scale 1-10): ________.
   (Please refer to pain scale drawings.)

**The remainder of these questions refer to your headaches as they are now (in approximately the past the three months).**

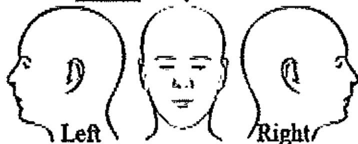
5. Frequency of all headaches of ANY severity or location: _____days per _____week_____month____year
6. Do you have a headache daily? (of any severity) _____Yes_____No
   If yes, are you ever headache free? _____Yes _____No
   If yes, for how many hours are you headache free? _____daily _____weekly

7. Severity of your **worst** headaches (scale 1-10):______(refer to pain scale drawings.)
8. Frequency of your **worst** headaches: _____days per _____week _____month ____year
9. Severity of **most** of your headaches (scale 1-10): _____
10. Frequency of headaches described in #9. _____ days per _____ week _____ month _____year

11. Location of your **worst** headaches: (mark the areas)




12. Location of **most** of your headaches: (mark the areas)




13. Duration of your **worst** headaches:
    Without treatment: _______minutes ______hours _____ days
    With treatment: _____minutes _____ hours _____ days

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14. Duration of **most** of your headaches:
    Without treatment: _______minutes ______hours _____ days
    With treatment: _____minutes _____ hours _____ days
    ______Headache all the time

15. Description of your **worst** headaches:
    _____throbbing _____squeezing _____dull _____stabbing _____shooting _____pounding
    _____burning _____knifelike _____achy _____pressure _____other

16. Description of **most** of your headaches:
    _____throbbing _____squeezing _____dull _____stabbing _____shooting _____pounding
    _____burning _____knifelike _____achy _____pressure _____other

17. Time of day headache is worse: ______________ ____No pattern
18. Day of the week headache is worse:___________ ____No pattern
19. Season of the year headache is worse:__________ ____No pattern
20. Do you experience sudden headaches on one side of the head? _____Yes _____No
    If yes:
    Which side? _____Left _____Right _____Can be either one
    The pain is: _____excruciating (Pain scale 9-10)
    _____7-8
    _____5-6
    _____other

    The pain is: _____ immediate onset (occurs in seconds)
    _____ fast onset (1-15 minutes)
    _____moderate onset (15-60 minutes)

    The frequency is: _____daily
    _____ several times a day. (How many?_____)
    _____ every other day
    _____ other:_________

    Is the pain in one eye? _____Yes _____No
    If yes which one? _____Right _____Left
    _____ The eye becomes red.
    _____ The eye starts to tear.
    _____ The eyelid droops.
    _____ There is sudden nasal congestion.
    _____ There is sudden nasal drainage.

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21. During the headache are you more comfortable:
    - _____ Lying down
    - _____ Keeping active
    - _____ Massage/Pressure
    - _____ Dark quiet room
    - _____ Pacing
    - _____ Other _____________________________________

22. Ability to function during your **worst** headaches:
    - _____ Able to function normally
    - _____ Ability to function slightly decreased
    - _____ Ability to function severely decreased
    - _____ Totally bedridden

23. Ability to function during **most** of your headaches:
    - _____ Able to function normally
    - _____ Ability to function slightly decreased
    - _____ Ability to function severely decreased
    - _____ Totally bedridden

24. Do you miss work/school because of headaches? _____Yes _____No
    (circle one)
    How often?__________

25. Please mark what can bring on your headaches (Triggers):
    - _____ Foods
    - _____ Caffeine
    - _____ Hunger
    - _____ Alcohol
    - _____ Aspartame
    - _____ Chocolate
    - _____ MSG
    - _____ Altered eating schedule
    - _____ Fatigue
    - _____ Coughing
    - _____ Bending over
    - _____ Straining
    - _____ Standing up
    - _____ Lying down
    - _____High altitude
    - _____ Medications
    - _____ Physical exertion
    - _____ Sex/Orgasm
    - _____ Menstration/Premenstral
    - _____ Lack of sleep
    - _____ Too much sleep
    - _____ Stress
    - _____ Neck movement
    - _____ Weather changes
    - _____ Bright lights or sun (photophobia)
    - _____ Loud sounds (phonophobia)
    - _____ Odors (osmophobia)
    - _____ Others ______________________

26. Please mark the warning signs that a headache is coming (Prodromes):
    - _____ Visual light flashes
    - _____ Visual zigzag lines
    - _____ Blindness
    - _____ Numbness on one side of body
    - _____ Other ______________________________
    - _____ Weakness on one side of body
    - _____ Dizziness/lightheadedness
    - _____ Upset stomach
    - _____ Speech difficulties

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Name ______________________________ Date of Birth_________ Date Completed________________

27. Associated symptoms during headache:

_____ Nausea
_____ Vomiting
_____ Increased appetite
_____ Decreased appetite
_____ Constipation
_____ Diarrhea
_____ Ringing in ears
_____ One eye tears
_____ Both eyes tear
_____ Insomnia
_____ Anxiety/tension
_____ Irritablity
_____ Blurry vision
_____ Double vision
_____ Increased urination
_____ Face droops on one side
_____ Pupils unequal
_____Sensitivity of scalp or skin of face (Allodynia)
  _____ Heat
  _____ Pulling hair back
  _____ Wearing contacts
  _____ Shaving face
  _____ Air conditioning or cold
  _____ Combing hair
  _____ Wearing eyeglasses
  _____ Wearing earrings
  _____ Taking a shower
  _____ Anything touching scalp
_____ Concentration/Memory loss
_____ Fatigue
_____ Weakness on one side of body
_____ Weakness all over
_____ Dizziness/lightheaded
_____ Sore/stiff neck
_____ Numbness/tingling one side of body
_____ Numbness/tingling both sides of body
_____ Sensitive to:
  ____Light _____Sounds_____Odors
_____ Passing out
_____ Eyelid droops
_____ Seizure
_____ Speech difficulties
_____ Face twitches
_____ Face/scalp swells
_____ Confusion

_____ Other ______________________________

28. How well do you sleep?

_____ Sleep well all night
_____ Sleep poorly
_____ Trouble falling asleep
_____ Wake several times
_____ Wake up too early
_____ Headache wakes from sleep

29. Do you clench your teeth? _____Yes _____No _____Don't know
30. Do you grind your teeth at night? _____Yes _____No _____Don't know
31. Does your neck hurt during a headache? _____Yes _____No
32. Does your neck hurt when you don't have a headache? _____Yes _____No
33. Does the position of your neck on the pillow affect headaches or neck pain? _____Yes _____No

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Name ______________________________ Date of Birth_________ Date Completed________________

34. How often do you go the ER for headaches? __________________
35. Have you ever been admitted to a hospital for headaches? _____Yes _____No
36. Have you had an eye examination in the last 6 month? _____Yes _____No
37. Have you had a dental evaluation? _____Yes _____No
38. Have you had psychological testing? _____Yes _____No
39. Previous non-medicinal treatment:

    _____ Biofeedback
    _____ Relaxation
    _____ Hypnosis
    _____ Physical therapy
    _____ Nutritional counseling
    _____ Acupuncture/acupressure
    _____ Allergy testing
    _____ Other ______________________________

# Cumberland Neurology Group
# Headache History Form

Name ______________________________ Date of Birth_________ Date Completed_______________

This questionnaire consists of 17 groups of statements. After reading each group of statements carefully, circle the number (0,1,2, or 3) next to the statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1.
- 0 I do not feel sad
- 1 I feel sad.
- 2 I am sad all the time and I can't snap out of it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel that the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get a real satisfaction out of anything I do anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty.
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.

7.
- 0 I don't feel I am worse than anybody else.
- 1 I am critical of myself for my weakness or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

8.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

9.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

10.
- 0 I am no more irritated now that I ever am.
- 1 I get annoyed or irritated more easily that I used to.
- 2 I feel irritated all the time now.
- 3 I don't get irritated at all by the things that used to irritate me.

11.
- 0 I have not lost interest in other people.
- 1 I am less interested in other people that I used to be.
- 2 I have lost most of my interest in other people.
- 3 I have lost all of my interest in other people.

12.
- 0 I don't feel I look any worse than I used to.
- 1 I am worried that I am looking old and unattractive.
- 2 I feel there are permanent changes in my appearance that make me look unattractive.
- 3 I believe that I look ugly.

13.
- 0 I can work about as well as before.
- 1 It takes an effort to get started doing something.
- 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
- 3 I wake up several hours earlier than I used to and cannot go back to sleep.

Name ____________________________ Date of Birth________ Date Completed_______________

14. 0 I don't get more tired that usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

15. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

16. 0 I haven't lost much weight, if any, lately.
    1 I have lost more than 5 pounds.
    2 I have lost more than 10 pounds.
    3 I have lost more than 15 pounds.

    I am purposely trying to lose weight by eating less. ____Yes _____No

17. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems such as aches and pains; upset stomach or constipation.
    2 I am very worried about physical problems and it's hard to think of much else.
    3 I am so worried about physical problems that I cannot think about anything else.

# Cumberland Neurology Group
# Headache History Form

Name ______________________________ Date of Birth_________ Date Completed_______________

The Migraine Disability Assessment (MIDAS) questionnaire was developed to measure the effect migraine headaches have on your daily function. It tries to determine how many days of your life were affected to the point that you were unable to function in a way to which you are accustomed. MIDAS takes into account the past three months when asking the questions.

## MIDAS Questions

Please answer the following questions about ALL your headaches you have had over the last 3 months. Write your answer in the blank next to each question. Write zero if you did not do the activity in the last 3 months.

1. On how many days in the last 3 months did you miss work or school because your headaches? _____ 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.) _____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 three months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.) _____days

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

**TOTAL** _____

A. On how many days in the last 3 months did you have a headache? (*If a headache lasted more than 1 day, count each day.*) _____days

B. On a scale of 0 to 10, on average how painful were these headaches? (*where 0 = no pain at all and 10 = pain as bad as it can be.*) ____

Once you've answered these questions, add up the total number of days from questions 1-5 (ignore A and B).

| Grade | Definition | Score |
|---|---|---|
| I | Little or no disability | 0-5 |
| II | Mild disability | 6-10 |
| III | Moderate disability | 11-20 |
| IV | Severe disability | 21+ |

**Cumberland Neurology Group**
**Headache History Form**

Name ______________________________ Date of Birth_________ Date Completed________________

How many days in an average week/month do you take medication on an as-needed basis for headaches? *Include all over-the-counter medications such as Excedrin Migraine, Ibuprofen, Goody's Powder, etc. and include prescription as-needed medications. Do not include prescription preventative medications or herbals that have instructions to take regularly.*

_______________days per ____week ____month
*(check one)*

List all medications you take for pain (any pain), frequency of use and for how long. Include all over the counter medications.

| Medication | | How long? |
|---|---|---|
| _________________________________ | _____Days per ____week _____month | _________ |
| _________________________________ | _____Days per ____week _____month | _________ |
| _________________________________ | _____Days per ____week _____month | _________ |
| _________________________________ | _____Days per ____week _____month | _________ |
| _________________________________ | _____Days per ____week _____month | _________ |
| _________________________________ | _____Days per ____week _____month | _________ |
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| _________________________________ | _____Days per ____week _____month | _________ |
| _________________________________ | _____Days per ____week _____month | _________ |