Headache New Patient Questionnaire

Patient name: ___________________________ Date of birth: ___________________________

How many days in the last 4 weeks (28 days) did you have headaches? Total should equal 28.

- Severe: _______  - Moderate: _______  - Mild: _______  - No headache: _______

How many days in the past 4 weeks did you need to take medicine for headaches? ________________

Circle all that apply.

Onset: ___________________________

Pain location: Bilateral  Right-unilateral  Occipital  Retro-orbital  Vertex
Left-unilateral  Frontal  Parietal  Temporal

Pain radiates to: Does not radiate  Face  Right neck  Right shoulder  Right arm
Left neck  Left shoulder  Left arm  Upper back  Lower back

Pain quality: Aching  Boring  Pulsating  Shooting  Squeezing  Thunderclap
Band-like  Dull  Sharp  Stabbing  Throbbing  Pressure

Associated Symptoms:
Abdominal pain  Facial swelling  Scalp tenderness
Abnormal behavior  Fever  Seizures
Anorexia  Hearing loss  Sinus pressure
Back pain  Insomnia  Sore throat
Blurred vision  Loss of balance  Swollen glands
Cough  Muscle aches  Tingling
Dizziness  Nausea  Tinnitus
Drainage  Neck pain  Visual change
Ear pain  Numbness  Vomiting
Eye pain  Phonophobia  Weakness
Eye redness  Photophobia  Weight loss
Eye watering  Rhinorrhea

Aggravated by:
Nothing  Coughing  Intercourse  Sneezing
Activity  Emotional stress  Medications  Weather changes
Alcohol  Exposure to cold air  Menstrual cycle  Work
Bright light  Fatigue  MSG  Valsalva
Caffeine Withdrawal  Food  Noise  Unknown
Chewing  Hunger  OPCs

How long does the headache last: ___________________________

Any warning that headaches are starting: ___________________________

Any other details you would like to share or feel that are important:

_____________________________
MIDAS Questionnaire
1. How many days in the last 3 months did you miss work or school because of your headaches? ________
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.) ________
3. How many days in the last 3 months did you not do house work because of your headaches? ________
4. How many days in the last 3 months was your productivity in house work reduced by half or more because of your headaches? (Do not include days you counted in question 3 where you did not do house work.) ________
5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches? ________

Total ________

PHQ-9
Over the last 2 weeks, how often have you been bothered by any of the following problems?
Circle your answer: Not at all – 0  Several days – 1  More than half the days – 2  Nearly every day – 3

1. Little interest or pleasure in doing things 0 1 2 3
2. Feeling down, depressed, or hopeless 0 1 2 3
3. Trouble falling or staying asleep, or sleeping too much 0 1 2 3
4. Feeling tired or having little energy 0 1 2 3
5. Poor appetite or overeating 0 1 2 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down 0 1 2 3
7. Trouble concentrating on things, such as reading the newspaper or watching television 0 1 2 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual 0 1 2 3
9. Thoughts that you would be better off dead or hurting yourself in some way 0 1 2 3

If you circled any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
Not difficult at all  Somewhat difficult  Very difficult  Extremely difficult
Total score ____________________

Female patients:
Are you pregnant? ________ Are you breast-feeding? ________ Are you using birth control? ________
Are you currently having menstrual cycles? ________ Are your menstrual cycles regular? ________
Have you had a hysterectomy? ________ Were your ovaries removed? ________
Are you taking hormone replacement therapy? ________
Are your headaches related to your periods? ________

Epworth Sleepiness Scale
The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. Use the following scale to choose the most appropriate number for each situation over the past 2 weeks. Even if you don’t usually do this activity, please give your best estimate:
0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Patient Name: __________________________
DOB: __________________________
Name / MR # / Label
**Situation**

Chance of dozing or sleeping

- Sitting and reading
- Watching TV
- Sitting inactive in a public place
- Being a passenger in a motor vehicle or an hour or more
- Lying down in the afternoon
- Sitting and talking to someone
- Sitting quietly after lunch (no alcohol)
- Stopped for a few minutes in traffic

**Total score**

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**Family history**

Have any members of your family (blood kin) ever been diagnosed with:

- Heart disease
  - Yes
  - No
- High blood pressure
  - Yes
  - No
- Diabetes
  - Yes
  - No
- Cancer
  - Yes
  - No

Does anyone in your family suffer from headaches? If so, who?

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**Social history**

Did you have a happy childhood?  Yes    No
If not, why?

Have you ever been a victim of abuse?  Yes    No
If yes, what type?  Physical    Sexual    Verbal/emotional

Educational level

Job satisfaction: Minimal  Moderate  Great
Job stress?

Caffeine use: Coffee cups #
Tea
Sodas
Type(s)

Alcohol use: # of days per week
Problem with alcohol?

Tobacco use: smoke now?  Yes    No
# of packs a day
Years
Smoked in past?  Yes    No

Use of illicit drugs: Yes    No
Present
Past
Type

Exercise: # of days per week
Time per day
minutes
Type

What do you do for fun?

Describe present emotional stressors:

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**Past medical history** (please list any medical problems you may have):

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**Past surgical history** (please list any surgeries you may have had):

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Headache New Patient Questionnaire

Review of systems

Constitution
Activity change
Appetite change
Chills
Diaphoresis
Fatigue
Fever
Unexpected weight change

Hent
Facial swelling
Neck pain
Neck stiffness
Ear discharge
Hearing loss
Ear pain
Tinnitus
Nosebleeds
Congestion
Rhinorrhea
Post nasal drip
Sneezing
Sinus pressure
Dental problem
Drooling
Mouth sores
Sore throat
Trouble swallowing
Voice Change

Eyes
Eye pain
Photophobia
Visual disturbance

Respiratory
Apnea
Chest tightness
Cough
Shortness of breath
Wheezing

Cardiovascular
Chest pain
Leg swelling
Palpitations

GI
Abdominal pain
Blood in stool
Constipation
Diarrhea
Nausea
Vomiting

Endocrine
Cold intolerance

GU
Difficulty urinating
Dysuria
Enuresis
Flank pain
Frequent urination
Hematuria
Urgent urination
Decreased urine

Muscle
Joint pain
Back pain
Incoordination
Joint swelling
Muscle pain

Skin
Rash

Allergy/Immuino
Environmental Allergy
Food allergies
Immunocompromised

Neurological
Dizziness
Facial asymmetry
Headaches

Hematologic
Bruises
Bleeds easily

Psychiatric
Agitation
Behavior problem
Confusion
Decreased concentration
Dysphoric mood
Hallucinations
Hyperactive
Nervous
Anxious
Self-injury
Sleep disturbance
Suicidal thoughts

Current medications:

Allergies:

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

[ ] Interpreter Accepted
[ ] Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Winston Neurology Headache Clinic
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Patient Name: __________________________
DOB: __________________________
(or use patient label)

Name / MR # / Label