CENTRAL IOWA
NEUROLOGY, P C

Headache Questionnaire

Name: _____ DOB: _____ Date: _____

Tell us About Your Headaches

How long have you had headaches? _____

A typical headache lasts _____. The longest headache I had lasted _____.

My headaches can most often be described as (check all that apply):
_____ Pounding ___ Pressure ____ Sharp _____ Stabbing ____ Tightness around head _____ Aching

My headaches are typically located:
_____ Entire head ___ Front of head_____ Back of head _____ Base of skull _____ Right side
_____ Left side ____ Behind right eye _____ Behind left eye _____ Wraps around head

As a result of my headaches I also feel:
_____ Nausea _____ Sensitive to light ___ Sensitive to noise ___ Sensitive to smells _____ Vomit

What things can TRIGGER a headache (or make one worse):
_____Strong smells _____ Caffeine ____ Alcohol _____ Physical activity ____ Changes in weather
_____ Bright lights _____ Loud noises _____ Female menstruation Other _____

In the last 3 months, I have been to the ER or Urgent Care _____ times for headaches.

In the last year, I have seen the following doctors for my headaches:
Physician Name: _____ Clinic: _____
Physician Name: _____ Clinic: _____
Physician Name: _____ Clinic: _____

Have you had either of the following tests performed:
_____ CAT scan When: _____ Where: _____ Results: _____
_____ MRI of brain When: _____ Where: _____ Results: _____

I have been diagnosed by a doctor or health professional with:
_____ Migraine headaches _____ Tension headaches _____ Mixed headache ____ Cluster
_____ TMJ _____ Atypical face pain _____ New onset headache _____ Other headache type

Past Medical History

Other medical conditions that I have been diagnosed with include:

_____Seizures	_____ Stroke	_____ TIA	_____MI	_____ COPD
_____ Asthma	_____ Arthritis	_____ Fibromyalgia		_____Diabetes
_____ Sleep Disorder	_____ Restless leg	_____ Major infection		_____ Hypertension
_____ MS	_____ Hypothyroidism	_____ High cholesterol		_____Depression
_____ Cancer	_____ Panic Attacks	_____ Anxiety		_____ Concussion

I have had the following surgeries:
_____ No surgeries _____ Tonsillectomy _____ Appendectomy
_____ Gallbladder _____ Heart _____ Spine (Area: _____)

Accidents and Injuries:
_____ I have never had a significant accident or injury.
_____ I have had the following accidents and/or injuries. _____
_____
_____

Females only: Date of last menstrual period: _____ Periods are _____ Regular _____Irregular
I could be pregnant: _____ Yes _____ No _____ Post Menopause

Over the past 30 days, I have had concerns regarding the following:
_____ **No concerns** _____ Fatigue _____ Chest pain _____ Heart palpitations
_____ Breathing _____ Swallowing _____Fainting _____Nausea
_____ Headaches _____ Neck pain _____ Back pain _____ Skin changes
_____ Memory _____Depression _____ Anxiety _____ Anger
_____ Urinary/Bowel problems _____ Arm/Leg weakness _____ Sleep issues
_____ Visual problems _____ Hearing problems

Family History

_____ Migraines Who:_____
_____ Seizures Who: _____
_____ Neuromuscular disorders Who: _____

Social History

Do you smoke or chew tobacco products? __ No __ Yes
If yes, how much per day _____ and for how long _____

Do you drink alcohol? _____ No __ Yes
If yes, how much per day _____ and for how long _____

Do you drink caffeinated products (soda, energy drinks, coffee, etc.) ____ No __ Yes
If yes, how much per day _____ and for how long _____

Do you use "street drugs" ___ No __ Yes
If yes, which ones _____, how often _____, for how long _____.

Marital Status: _____ Single _____ Married _____ Divorced ____ Widowed

Employment Status: _____ Employed _____ Not currently employed (If not working, please explain why _____
_____

Education: _____ High school graduate/GED _____ AA degree _____ Bachelor Degree
_____ Master's Degree _____ Doctoral degree

Allergies

Medications:_____

Other allergies: _____

Current Medications: _____

_____

_____

_____

Circle any of the following medications/treatments you have tried for at least 6 weeks. Underline any of the medications/treatments that you have tried for any length of time.

Preventive Medications

Topiramate (Topamax)	Divalpoex sodium (Depakote)	Propranol (Inderol)
Metoprolol (Lopressor)	Petasites (Butterbur)	Candesartan (Atacand)
Amitriptyline (Elavil)	Venlafaxine (Effexor)	Fenoprofen (Nalfon)
Magnesium oxide	Riboflavin (B2)	CoQ10
Clonidine (Catapres)	Lisinopril (Zestril)	Indomethacin (Indocin)
Tizandine Zanaflex)	Fluxetine (Prozac)	Imipramine (Tofranil)
Verapamil (Calan)	Herbal therapies	

Abortive Medications

Amerge (Naratriptan)	Zomig (Zolmitriptan)	Maxalt (Rizatriptan)
Frova (Frovatriptan)	Relpax (Eletriptan)	Axert (Almotriptan)
Treximate (Sumatriptan/Naproxen Sodium)		Migranal (Dihydroergotamine)
Ergotamine Tartrate	DHE-45	Naproxen (Naprosyn)
Diclofenac (Cataflam)	Dicloflenac (Cambia)	Dexamethasone
Prednisone	Herbals	

Rescue Medications

Mefanamic Acid (Ponstel)	Metaxalone (Skelaxin)	Metoclopramide (Reglan)
Phenothiazine (Promethazine)	Prochlorperazine	Kerorolac Spray (Sprix)
Narcotics/Opoids		

What other treatments or therapies have you tried to manage your headaches:

_____ Acupuncture _____ Chiropractic _____ Osteopathic massage _____ Cefaly

_____ Nerve blocks_____ Ice _____ Physical therapy _____ Yoga

_____ Biofeedback _____ Cognitive behavioral therapy

The Migraine Disability Assessment Test

The MIDAS (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS: Please answer the following questions about ALL of the headaches you have had over the last **3 months**. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months.

_____ On how many days in the last 3 months did you miss work because of your headaches?

_____ How many days in the last 3 months was your productivity at work reduced by half or more because of your headaches? (Do not include the days you counted in the above question where you missed work)

_____ On how many days in the last 3 months did you not do household work (such as housework, home repairs, maintenance, shopping, caring for children or relatives) because of your headaches?

_____ 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 the days you counted in the above question).

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

_____ **Total** of the above five questions.

What your physician will need to know about your headache:

_____ 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.)

_____ On a scale of 0-10, on average how painful were these headaches? (O= no pain to 10= really bad)

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

If your MIDAS score is 6 or more, please discuss this with your doctor.