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CNOS
SPECIALIZING IN YOUR HEALTH

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Headache Questionnaire

Name:_____ Date:_____ Age:_____ Sex: ❑ M ❑ F

Headaches started at age:_____

Cause
Injury: Type:_____ Date of injury:_____
Infection:_____ Pregnancy:_____
Emotional Stress:_____ Other:_____

Frequency
Headaches Occur:_____times per day/week/month:_____
Are they increasing?_____

Location
❑ Left Side ❑ Right Side ❑ Either Side ❑ All Over Head
❑ Face/Jaw ❑ Usually in one place ❑ Move Around ❑ Seldom/Often

Duration
Last:_____ If not treated:_____
Last:_____ If treated immediately:_____
Last:_____ If treated after they are severe:_____
Free of headaches from:_____ to _____
Never have been free of headaches:_____

Precipitating Factors
Can be brought on by:
❑ Fatique ❑ Stress/Tension ❑ Oversleeping ❑ Certain Foods
❑ Alcohol ❑ Certain Medications ❑ Menstruation ❑ Coughing
❑ Lying Down ❑ Washing ❑ Chewing ❑ Talking
❑ Shaving or Touching Face ❑ Stooping ❑ Exercise ❑ Other:_____

Hormonal (Women Only)
How are headaches affected by menstrual cycle?_____
How are headaches affected by pregnancy?_____

Seasonality
Are headaches more frequent in: ❑ Spring ❑ Summer ❑ Fall ❑ Winter ❑ Not Seasonal

Prodromata
Warning signs before headaches:
❑ Halos around eyes ❑ Blind spots ❑ Flashing lights ❑ Upset stomach
❑ Tightness around head ❑ Dizziness ❑ Light-headed ❑ Numbness in leg or arm
❑ Other:_____

Pain Type
Pain is:
- ❑ Throbbing
- ❑ Stabbing
- ❑ Dull
- ❑ Burning
- ❑ Sharp
- ❑ Other _____
- ❑ Tight band

Severity
Pain is:
- ❑ Mild to Moderate
- ❑ Severe
- ❑ Unbearable
- ❑ Prevent Normal activities such as work

Family History
Who in your family has suffered from headaches?_____
_____

Associated Symptoms
- ❑ Nausea & Vomiting
- ❑ Sound sensitivity
- ❑ Nasal congestion
- ❑ Frequent and/or early awakening
- ❑ Insomnia
- ❑ Ringing in ears
- ❑ Dizziness
- ❑ Other: _____
- ❑ Stiff Neck
- ❑ Eye tearing
- ❑ Paresthesia
- ❑ Light sensitivity
- ❑ Visual disturbance
- ❑ Dizziness

Previous Care
Other doctors seen for headache treatment:_____
Related tests/x-rays?_____
Medication for headaches:_____
Other treatments (i.e. biofeedback):_____

Medical History
Check those that apply:
- ❑ Asthma
- ❑ Eye problems
- ❑ Heart trouble
- ❑ Sinusitis
- ❑ Cancer/tumor
- ❑ Allergies
- ❑ High blood pressure
- ❑ Stomach/duodenal ulcer
- ❑ Diabetes
- ❑ Head injury
- ❑ Kidney/liver disease
- ❑ Epilepsy
- ❑ Hearing problems
- ❑ Nervous breakdown

Current medication other than that taken for headaches:_____
Allergic to medications:_____
Food Allergies (Check those that apply):
- ❑ Cheese
- ❑ MSG
- ❑ Chocolate
- ❑ Spicy foods
- ❑ Cola
- ❑ Other: _____
- ❑ Nuts

Hospitalization (for other than normal pregnancy):_____
_____
Do you consume caffeine? ❑ Yes ❑ No If yes, what is your daily consumption:_____
Do you consume alcohol? ❑ Yes ❑ No If yes, what is your daily consumption:_____
Do you use tobacco? ❑ Yes ❑ No If yes, what is your daily usage:_____
Do you have a history of drug abuse?_____
If yes, were the drugs: ❑ Prescribed ❑ Non-prescribed
Do you have a history of: ❑ Fainting ❑ Seizures

Women Only
_____ Number of pregnancies _____ Number of children born alive

Additional General Health Comments_____
_____
_____