CMH Neurology and Headache Center
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New Patient - Headache Questionnaire

This questionnaire is very important for your evaluation and should be completed BEFORE your appointment.
Please take the time and answer each question carefully. It shouldn't take long to complete.
Thank you for your time in filling this out.

Your Name (Last, First)	Your Date of Birth	Today's Date
What name do you like to be called? (e.g. full first name, nickname, etc.):		

1. When did headaches first occur in your life? (FOR EXAMPLE: How many weeks, months or years ago?)

2. How often do you have a headache now? (FOR EXAMPLE: How many days a week do you have any type of headache?)

3. How often do you have days without any type of headache?

4. Have you noticed anything that tends to trigger, or start, your headaches?

5. Is there a particular time of day that headaches tend to start? (FOR EXAMPLE: Morning, afternoon or evening? Or could they be at any time of the day?)

6. Is there any particular symptom that you tend to have before the pain of the headache starts? (FOR EXAMPLE: Is there a change in the way other parts of your body feel before the pain of headache starts?)

7. **Do you have changes in your vision before the pain of headache begins?** (FOR EXAMPLE: Do you see lines, lights, shimmers or have areas within your vision that are abnormal?)

8. **Is there a typical location that the pain of your headache starts?** (FOR EXAMPLE: Front, back, one side? Or, does the location vary from one headache to the next headache?)

9. **From the time that you first feel the pain of headache start until it gets to be as strong as it is going to get, most commonly how long does it take?** (FOR EXAMPLE: Seconds, minutes, or hours?)

10. **When your head pain is at its higher levels how do you describe the way the pain feels?** (FOR EXAMPLE: Tight, squeezing, sharp, jabbing, electrical, throbbing, pulsating, banging, etc.)

11. **On the scale where pain is rated from 0 to 10** (0 meaning no pain at all and 10 meaning the worst pain you have ever had), **how would you rate the headache pain for most of your headaches**?

12. **Do you have some headaches that go to higher pain levels than your typical headaches? If so, how often does that happen and how high would you rate them on the 0 to 10 pain scale?**

13. **How long do your most commonly occurring headaches last from the start of your headache until it has completely washed out of your system?**

14. **Do you have some headaches last longer than your typical headaches? If so, how often does that happen and how long do they last?**

15. Please check the box of any of the following symptoms that are present with your headaches:

☐Light sensitivity	☐Sound sensitivity	☐Sensitivity to odors
☐Nausea	☐Vomiting	☐Needs to reduce physical activity
☐Pounding with exertion	☐Tears from one eye	☐Redness in one eye
☐Stuffy nose on one side	☐Droopy eyelid on one side	☐Change in sweating on forehead

16. Is there anyone in your family that has headaches? ☐Yes ☐No
If so, whom? (FOR EXAMPLE: a parent, a brother or sister, a child)

17. How do you currently treat your headaches?

18. Do you use any "over-the-counter" medicines? ☐Yes ☐No
If so, what do you take and how often? (FOR EXAMPLE: How many at a time do you take, how many times a day will you take it, and how many days a week do you use it?)

19. Do you use any prescription medicines to treat a headache attack? ☐Yes ☐No
If so, what do you take and how often? (FOR EXAMPLE: How many at a time do you take, how many times a day will you take it, and how many days a week do you use it?)

20. Do you use any prescription medicines to prevent headache from happening? ☐Yes ☐No
    If so, what do you take and how often? (FOR EXAMPLE: How many at a time do you take, how many times a day will?)

21. How many caffeinated beverages do you drink on most days? (FOR EXAMPLE: Coffee, tea or iced tea, energy drinks)

22. How much water do you drink on most days?

23. Do you eat three meals? ☐Yes ☐No
    If NO, which meal(s) do you tend to skip?

24. Do you have an exercise program that you stick with? ☐Yes ☐No
    If YES, what do you do, how long each time and how often do you do it?

25. Do you use any artificial sweeteners? ☐Yes ☐No

26. Have you ever had a brain MRI or CT scan? ☐Yes ☐No
    If YES, when and where was the most recent scan done?

27. Have you ever seen a neurologist or headache specialist for your headaches? ☐Yes ☐No
    If YES, whom?

28. History of previous medications that you have used to TREAT headache attacks.

Click the box if you have taken it and make a note on how it worked or if it had side-effects:

☐ Axert (almotriptan)	☐ Tylenol (acetaminophen)
☐ Relpax (eletriptan)	☐ Excedrin (acetaminophen, aspirin, caffeine)
☐ Frova (frovatriptan)	☐ Fioricet (butalbital/acetaminophe/caffeine)
☐ Amerge (naratriptan)	☐ Fiorinal (butalbital/aspirin/caffeine)
☐ Maxalt (rizatriptan)	☐ Reglan (metoclopramide)
☐ Imitrex (sumatriptan)	☐ Compazine (prochlorperazine)
☐ Treximet (sumatriptan/naproxen)	☐ Phenergan (promethazine)
☐ Zomig (zolmitriptan)	☐ Zofran (ondansetron)
☐ Aspirin	☐ Vicodin (hydrocodone)
☐ Cambia (diclofenac)	☐ Percocet (oxycodone)
☐ Advil (ibuprofen)	☐ Ultram (tramadol)
☐ Aleve (naproxen)	Any Other Narcotic:
☐ Indocin (indomethacin)	☐ D.H.E. 45 (dihydroergotamine)
☐ Toradol (ketorolac)	☐ Oxygen
☐ Ubrelvy (ubrogepant)	☐ Nurtec ODT (rimegepant)
☐ Reyvow (lasmiditan)	

Please list any others: _____

29. History of previous medications that you have used to PREVENT headache attacks.

Check the box if you have taken it and make a note on how it worked or if it had side-effects:

☐Amitriptyline (Elavil)	☐Gabapentin (Neurontin)
☐Nortriptyline (Pamelor)	☐Pregabalin (Lyrica)
☐Metoprolol (Lopressor)	☐Venlafaxine (effexor)
☐Propranolol (Inderal)	☐OnabotulinumtoxinA (Botox)
☐Verapamil	☐Amovig (erenumab)
☐Candesartan (Atacand)	☐Ajovy (fremanezumab)
☐Lisinopril (Prinivil, Zestril)	☐Emgality (galcanezumab)
☐Topiramate (Topamax)	☐Vyepti (eptinezumab)
☐Zonisamide (Zonegran)	☐Magnesium
☐Valproic Acid (Depakote)	☐Vitamin B2 (Riboflavin)
☐Biofeedback	
☐Neuromodulator device (Cefaly, gammaCore, Nerivio, Spring TMS)	

Please list any others: _____

Note: If you have trouble submitting the questionnaire or receive an error message, please save the questionnaire to your desktop and email to neurology@citizensmemorial.com.

SUBMIT FORM ≫