Stony Brook Medicine

Headache Questionnaire

At what age did you have your first headache: ___________ What year did your current headaches begin: ___________

When was your last headache: ____

Are you ever free of pain completely? ❑ Yes ❑ No

Do you have more than one type of headaches? ❑ Yes ❑ No

If yes, describe them separately: ____

____

How many headaches (any type) do you have each month: ___________, how long do they last: ___________

How would you describe the pain of your most serious headaches (circle one or several):

throbbing ***pulsating*** ***dull*** ***aching*** ***pressure-like***

sharp ***stabbing*** ***electric-like*** ***vise-like***

Does the pain like: ❑ going from outside - in (compressing, stabbing) ❑ from inside - out (exploding, pushing out)

When you have a headache (and possibly after), does your scalp and face become sensitive to touch and do you avoid putting on glasses, jewelry or combing your hair? ❑ Yes ❑ No

Are your headaches brought on by:

your periods / hormonal changes ***exercise*** ***stress*** ***relaxation after stress*** ***change in weather***

alcohol ***bright light / glare*** ***odors*** ***smoke*** ***noise*** ***lack of sleep*** ***too much sleep*** ***hunger***

food additives ***certain foods***

Do your headaches occur on any particular day of the week or time of day? ______________________________

____

Do you have any warning signs before the start of a headache? ❑ Yes ❑ No

Describe: ____

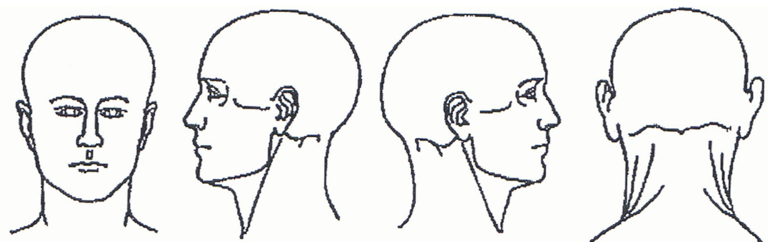
Circle any of the following symptoms you have with your headaches:

neck pain ***nausea*** ***vomiting*** ***light sensitivity*** ***dizziness*** ***noise sensitivity*** ***numbness***

weakness ***fever*** ***confusion*** ***difficulty speaking*** ***tearing*** ***nasal congestion*** ***eyelid drooping***

worsening of pain with movement ***other:*** ____

Please indicate with X's where you experience pain:



SBUH2012N082

Stony Brook Medicine

Headache Questionnaire

Have you ever been treated for headaches? ❑ Yes ❑ No

What kind of headaches were you told you have: ______________________________

Have you had any tests done to diagnose your headaches? ❑ Yes ❑ No

Describe: ______________________________

Which of the following medicines have you tried for your headaches (of any kind) (circle):

Anaprox	Codeine	Imitrex / Sumatriptan	Percogesic
Aspirin	Darvon / Darvocet	Inderal / Propranolol	Phrenilin Forte
Anacin	Dexamethasone / Decadron	Indocin / Indomethacin	Relpax
Advil / Ibuprofin	Decongestants	Lamictal	Robaxin
Aleve / Naproxen	DHE-45	Lidocaine	Timolol
Amerge	Demerol	Lithium	Toprol/Toprol XR
Axert	Depakote	Lyrica	Topamax / Topiramate
Amitriptyline / Elavil	Desyrel / Tradozone	Maxalt	Tylenol
Atacand	Dilantin / Phenytoin	Metoprolol	Ultram / Tramadol
Benicar	Effexor	Migralex	Ultracet
Beta-blockers	Esgic	Migranal	Valium
Botox	Excedrin	Motrin / Ibuprofin	Vivactyl / Protriptyline
Bufferin	Fioricet / Butalbital	Neurontin / Gabapentin	Xanax
Cafergot	Fiorinal / Butibital	Naprosyn / Anaprox	Zanaflex
Calan / Verapamil	Flexeril	Pamelor / Notriptyline	Zecuity
Cymbalta	Frova	Percocet / Oxycodone	Zomig
		Percodan	Zonegran

*Star those which helped, even for a while. Other:

Have you tried any of the following alternative treatments (circle):

Biofeedback ***Acupuncture*** ***Chiropractic*** ***Physical Therapy*** ***Other:*** ____________________

Supplements: (Feverfew, B2, Magnesium, MigreLief, CoQ10, Butterbur, Petadolex)

List all the headache medications and the amounts you are now taking (over the counter or prescribed):

- - -
- - -
- - -
- - -

List all other medications you are taking for any reason:

- - -
- - -
- - -
- - -

SBUH2012N082

Headache Questionnaire

MIDAS Questionnaire | Migraine Disability Assessment

Patient Name: ____ **Date:** ____________________________

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you.

INSTRUCTIONS: Please answer the following questions about all of your headaches over the last 3 months. Write your answer in the box 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 of your headaches? (if you do not attend work or school enter zero in the space to the right). ☐

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. If you do not attend work or school, enter zero in the space to the right). ☐

3. On how many days in the last 3 months did you not do household work because of your headaches? ☐

4. 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 days you counted in question 1 where you missed work or school. If you do not attend work or school, enter zero in the space to the right). ☐

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

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

B. On a scale of 0-10, on average, how painful were these headaches? (0 = no pain at all, and 10 = pain which is as bad as it can be.) ☐

Add the total number of days from questions 1 to 5 (ignore A and B). ☐

During the past month:

1) Have you been bothered a lot in the last month by feeling sad, down, or depressed? ❑ Yes ❑ No

2) Have you been bothered a lot in the last month by a loss of interest or pleasure in your daily activities? ❑ Yes ❑ No

For Men: When was the last time you had more then five drinks in one day?

❑ Never ❑ In the past three months ❑ Over three months ago

For Women: When was the last time you had more then four drinks in one day?

❑ Never ❑ In the past three months ❑ Over three months ago

SBUH2012N082

Stony Brook Medicine

Headache Questionnaire

Have you had any of the following problems in the past 6 months:

- ❑ Change in marital status
- ❑ Change in job / school
- ❑ New illness diagnosed
- ❑ Emotional trauma
- ❑ Change in smoking / drinking / diet
- ❑ Hospitalizations / surgery
- ❑ Fatigue
- ❑ Bruising
- ❑ Weight change; loss ______ lbs, gain ______ lbs
- ❑ Allergic reaction
- ❑ Skin rash
- ❑ Fever / chills
- ❑ High blood pressure
- ❑ Palpitations
- ❑ Breathing difficulty
- ❑ Chest pain
- ❑ Swelling
- ❑ Chronic cough
- ❑ Wheezing
- ❑ Bleeding / bruising
- ❑ Diarrhea
- ❑ Constipation
- ❑ Heartburn
- ❑ Stomack pain
- ❑ Nausea / vomiting
- ❑ Joint pain / swelling / redness
- ❑ Muscle aches
- ❑ Sexual dysfunction
- ❑ Breast lumps / discharge
- ❑ Symptoms of menopause
- ❑ Irregular periods
- ❑ PMS
- ❑ Bladder problems
- ❑ Cold extremities
- ❑ Leg / foot cramps
- ❑ Depression
- ❑ Anxiety / panic attacks
- ❑ Change in skin / hair
- ❑ Excessive urination or thirst
- ❑ Insomnia
- ❑ Leg restlessness
- ❑ Daytime sleepiness
- ❑ Snoring
- ❑ Sleep apnea
- ❑ Teeth grinding / clenching
- ❑ Seizures / shaking
- ❑ Headaches
- ❑ Back pain
- ❑ Neck pain
- ❑ Decline in memory
- ❑ Weakness
- ❑ Numbness
- ❑ Hearing problems
- ❑ Vision problems
- ❑ Loss of consciousness
- ❑ Dizziness
- ❑ Dental problems
- ❑ Sinus problems
- ❑ Hoarseness
- ❑ Any other problems not listed

SBUH2012N082

Stony Brook Medicine

Headache Questionnaire

Please list all of your present medical problems and doctors you are seeing: ____________________

____

____

____

Please list all past medical problems, operations, and hospital admissions: ____________________

____

____

____

Please list your allergies, if any: ____________________

____

Height: __________ Weight: __________

Amounts per day:

Alcohol: ________ Coffee: ________ Tea: ________ Tonic/Soda: ________ Water: ________

If you smoke, how much: ________ Recreational Drugs: ❑ Yes ❑ No

What time do you go to sleep and wake up? Weekdays: ________ Weekends: ________

Physical exercise / frequency / duration: ____________________

Present work status: ____________________ Do you like your job: ❑ Yes ❑ No ❑ Not Sure

If you have children, please list their ages: ____________________

Please list hobbies / recreational activities: ____________________

What is you current level of stress (0 = no stress, 10 = catastrophic): ________

Level of education: ____________________ Do you have pets: ❑ Yes ❑ No

With whom are you living with (list relationship and age): ____________________

Are there any serious problems at home: ❑ Yes ❑ No, if yes describe: ____________________

Is there a family history of (check all that apply):

❑ Headaches ❑ Heart Disease ❑ Alcoholism ❑ Tuberculosis ❑ Excessive Bleeding

❑ Seizures ❑ High Blood Pressure ❑ Goiter/Thyroid ❑ Mental Illness ❑ Cancer

❑ Strokes ❑ Arthritis ❑ Diabetes ❑ Obesity ❑ Sleep Disorders

❑ Other: ____________________

SBUH2012N082