# CHW-blk-with-PrimaryCare Headache History Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Dear Patient and/or Parent:***

# *You have been scheduled with one of our physicians to discuss concerns regarding chronic headaches. Please review the headache history form and answer the pertinent* *questions. Please bring the completed questionnaire with you on the day of your appointment. You may write directly on this form, using both sides as needed.*

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| 1. Do you have a single type of headache or several types of headaches? |
| 1. How did the headaches begin? Did you injure your head or neck? |
| 1. How long has each headache type been present? |
| 1. Are the headaches worsening in severity or staying the same? |
| 1. How frequently do the headaches occur? Are they becoming increasingly frequent? |
| 1. Do they occur under any special conditions, such as your period, or at examination time? Any special time or season? |
| 1. Are they related to specific foods? |
| 1. Are they preceded by warning signs? What are those signs-and how soon before the headache do you notice them? |
| 1. Where is the pain located? |
| 1. How would you describe the pain? Is it pounding? Squeezing? Sharp? Hammering? |
| 1. Are there symptoms that accompany the headache, such as nausea, vomiting, dizziness, or  light-headedness. Or weakness? Does light or sound bother you during a headache? |
| 1. What do you do during the headache? Do you stop playing? Do you have to lie down? |
| 1. How long does the headache last? |
| 1. What medications do you use or which maneuvers do you try to make the headache better? Does sleep relieve the headache? |
| 1. Does anything you do make the headache worse? |
| 1. Between headaches, do you have problems with your balance or vision? Do you feel tired or weak, or lose your temper? Do you feel restless? |
| 1. Are you being treated for, or do you have any chronic medical problems, such as sinusitis? Asthma? High blood pressure? |
| 1. Do you take medication for any other problems on a regular basis? |
| 1. Does anyone else in your family have headaches? What kind of headaches do they have? |
| 1. Can you tell me what you think is causing your headaches? |
| 1. Have you had any other medical problems in the past? Did you have any surgeries? |
| 1. (To the parents) Were there any problems during the pregnancy, labor, or delivery? |
| 1. Are there any problems at school or with your friends? |

\*Adapted from Rothner AD et al, In: Diamond ML, Solomon GD, eds. Diamond and Dalessio's The Practicing Physician's Approach to Headache. 1999.