HEADACHE HISTORY FORM

Your Name: ______________________________ Date: _____________________

Your age: ❍ between 10 and 30 ❍ 30 – 50 ❍ > 50

What is your headache complaint?

____

____

Where is your headache located?

How severe is your headache? (please rate the severity of your headache on the scale of 1 to 10, by placing an 'X' on the dotted line. 1 is the lowest and 10 is the worst)

Location: _______________________________________

| ………………………………………………………………………..|
0
10

Location: _______________________________________

| ………………………………………………………………………..|
0 10

Location: _______________________________________

| ………………………………………………………………………..|
0 10

How often do you have these headaches?

❍ 2 – 5 times per month

- ❍ less than 15 times per month
- ❍ 1 – 6 times daily for weeks to months
- ❍ increasing in frequency
- ❍ intermittent

How would you describe your headaches?

Side

❍ left side only ❍ right side only ❍ both sides

Description

- ❍ pulsating
- ❍ throbbing
- ❍ tight band / vice around your head
- ❍ pressing
- ❍ shock-like
- ❍ stabbing / jabbing like a thunderclap
- ❍ burning
- ❍ explosive

Intensity

- ❍ mild
- ❍ moderate
- ❍ severe
- ❍ stable
- ❍ improving
- ❍ steadily worsening

Location

- ❍ generalised (all over)
- ❍ frontal (above your eye brows)
- ❍ over your jaw joints
- ❍ temple
- ❍ top of your head
- ❍ back of your head at the hair line
- ❍ behind your eyes
- ❍ around your eyes
- ❍ side of your head
- ❍ directly in front of your ears
- ❍ behind your ears
- ❍ upper back teeth
- ❍ lower back teeth
- ❍ upper front teeth
- ❍ lower front teeth
- ❍ generalised (all teeth)
- ❍ nose ❍ on one side only ❍ both sides
- ❍ cheeks ❍ on one side only ❍ both sides
- ❍ gums ❍ on one side only ❍ both sides
- ❍ teeth ❍ Upper: on one side only ❍ Upper and lower: on one side only

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- ❍ over all teeth ❍ front teeth ❍ back teeth

What brings on your headaches?

- ❍ mental / intellectual exertion
- ❍ exercises
- ❍ orgasm (sex)
- ❍ medications e.g. non-steroidal anti-inflammatories, valium, nitroglycerine,
  Please state: ____
- ❍ foods and food additives
- ❍ food allergies
- ❍ smoking
- ❍ neck movements
- ❍ bright lights / sun
- ❍ fatigue
- ❍ sleep loss / insomnia / poor interrupted or disturbed sleep / too much sleep
- ❍ hypoglycaemia (low blood sugar levels)
- ❍ stress
- ❍ alcohol
- ❍ menstruation / hormonal changes
- ❍ exposure of head to cold temperatures
- ❍ washing your face
- ❍ shaving
- ❍ brushing your teeth
- ❍ talking

How long do your headaches last?

- ❍ less than 1 minute
- ❍ several minutes
- ❍ 15 to 30 minutes
- ❍ 30 to 90 minutes
- ❍ less than or up to 24 hours
- ❍ 4 to 72 hours
- ❍ from 30 minutes up to 1 week
- ❍ continuous
- ❍ transient / on and off

What makes your headaches worse?

- ❍ allergy season
- ❍ loud noises
- ❍ certain foods
- ❍ dental treatment
- ❍ bending head forward
- ❍ standing upright
- ❍ bright lights
- ❍ physical exertion
- ❍ antidepressant or nerve pain medications
- ❍ body or head movement
- ❍ jarring of the head
- ❍ coughing

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What improves your headaches?

- ❍ hot packs
- ❍ medications
    - ❍ non-narcotic analgesics (pain killers)
    - ❍ non-steroidal anti-inflammatories
    - ❍ migraine medications
    - ❍ antidepressants
    - ❍ muscle relaxants
    - ❍ lithium
    - ❍ indomethacin
- ❍ lying down
- ❍ rest
- ❍ dark room
- ❍ tractioning the neck
- ❍ caffeine

Have you ever had a break / remission from your headaches?

❍ never ❍ yes – months ❍ yes – months to years

ONSET

How and when did you start getting your headaches?

- ❍ no history of previous headache until recently
- ❍ long history of headache
- ❍ during a period of stress
- ❍ following head injury / head trauma
- ❍ sudden onset
- ❍ gradual onset
- ❍ 2 hours after going to bed
- ❍ with exertion / neck movement

At what age did you start getting bad headaches?

- ❍ 0 – 10 years old
- ❍ 10 – 20 years old
- ❍ 20 – 40 years old
- ❍ 40 – 50 years old
- ❍ over 50 years old

Has your headache been getting worse? ❍ Yes ❍ No

When you were a child, did you have

Car / motor sickness? ❍ Yes ❍ No
Drooping / lazy eye? ❍ Yes ❍ No

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Childhood headaches? ❍ Yes ❍ No
Double vision? ❍ Yes ❍ No

What other symptoms do you suffer from?

Before your headaches
(hours to 2 days before)
❍ lethargy
❍ hyperactivity
❍ depression
❍ food cravings
❍ appetite loss / anorexia
❍ fluid retention
❍ diarrhoea
❍ urticaria

Before your headaches
(up to 60 minutes before)
❍ scotoma (area of visual loss)
  ❍ partial
  ❍ worsening
  ❍ complete
❍ scintillation (shimmering borders) /
fortification (zig zag forms)
❍ crescent figures (crescent-shaped areas
of visual loss)
❍ scintillating edges
❍ photopsia (flashing light or colours)

During your headaches

❍ nausea
❍ vomiting
❍ photo-phobia (sensitive to bright lights)
❍ phono – phobia (sensitive to noise)
❍ osmophobia (sensitive to smells)
❍ vertigo (loss of balance)
❍ fatigue
❍ anorexia
❍ malaise (generally feeling unwell)
❍ asthenia (lack of strength)
❍ sweating: ❍ day ❍ night
❍ miosis (excessive contraction of the
pupil of the eye)
❍ stomach / intestinal upset

Previous Medical History

Do you have a history of:

Heart / circulatory problems?	❍ Yes	❍ No
High blood pressure (especially diastolic)?	❍ Yes	❍ No
High cholesterol?	❍ Yes	❍ No
Recent lumbar puncture procedure?	❍ Yes	❍ No
Urticaria?	❍ Yes	❍ No
Nasal congestion?	❍ Yes	❍ No
Sinus problems?	❍ Yes	❍ No
Pheochromocytoma?	❍ Yes	❍ No
Loss of / compromised vision?	❍ Yes	❍ No
Failing eyesight?	❍ Yes	❍ No
Blurred vision?	❍ Yes	❍ No
Visual aura?	❍ Yes	❍ No
Lacrimation (tearing)?	❍ Yes	❍ No
Sore throat?	❍ Yes	❍ No
Clicking jaw?	❍ Yes	❍ No
Locking jaw?	❍ Yes	❍ No
Pain on chewing?	❍ Yes	❍ No
Sore jaw?	❍ Yes	❍ No
Teeth clenching / grinding (during the day)?	❍ Yes	❍ No
Teeth clenching / grinding (during sleep)?	❍ Yes	❍ No
Dizziness?	❍ Yes	❍ No
Tinnitus (ringing in ears)?	❍ Yes	❍ No
Loss of / worsening hearing?	❍ Yes	❍ No
Ear infection?	❍ Yes	❍ No
Blocked ears (cannot be cleared by swallowing)?	❍ Yes	❍ No
Head and / or neck trauma?	❍ Yes	❍ No
Whiplash?	❍ Yes	❍ No
Loss of consciousness?	❍ Yes	❍ No
Irritable bowel syndrome?	❍ Yes	❍ No
Fibromyalgia?	❍ Yes	❍ No
Diabetes / diabetic neuropathy?	❍ Yes	❍ No
Herpes?	❍ Yes	❍ No
Pyrexia (fever)?	❍ Yes	❍ No
Hydrocephalus?	❍ Yes	❍ No
Raised ESR (erythrocyte sedimentation rate) in blood test?	❍ Yes	❍ No

Do you take / have you taken the following medications?

Barbiturates	❍ Yes	❍ No
Ergotamines	❍ Yes	❍ No
Analgesics (pain killers)	❍ Yes	❍ No
Contraceptives (birth control pills)	❍ Yes	❍ No
Tricyclic anti-depressants	❍ Yes	❍ No

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Cimetidine (usually used for peptic ulcers)	❍ Yes	❍ No
Selective serotonin re-uptake inhibitors (e.g. Prozac, Cipramil, Efexor)	❍ Yes	❍ No
Corticol steroids	❍ Yes	❍ No
Trimethoprim / sulfamethozazole (e.g. Bactrim, Septrin)	❍ Yes	❍ No
Hormone replacement therapy	❍ Yes	❍ No
Long term antibiotics	❍ Yes	❍ No
Artane	❍ Yes	❍ No
Anti-migraine medication	❍ Yes	❍ No
Did the anti-migraine medication help you?	❍ Yes	❍ No

Do you smoke? ❍ Yes ❍ No

Is there a family history of:

Heart problems?	❍ Yes	❍ No
Strokes?	❍ Yes	❍ No
Headaches?	❍ Yes	❍ No

Do you suffer from:

- ❍ depression
- ❍ bipolar disorder
- ❍ borderline personality disorder
- ❍ eating disorder
- ❍ obsessive compulsive disorder
- ❍ appetite change
- ❍ insomnia
- ❍ sexual dysfunction
- ❍ decreased libido
- ❍ anhedonia (inability to experience pleasure)
- ❍ restlessness
- ❍ anxiety / panic attacks
- ❍ irritability
- ❍ loss of memory
- ❍ chronic fatigue
- ❍ difficulty concentrating

During your headaches, do you feel

❍ active? ❍ restless? ❍ pacing?

Sleep history

Do you suffer from / have the following:

- ❍ loss of sleep
- ❍ insomnia (sleeplessness)
- ❍ dyssomnia (sleep problems)
- ❍ explosive headache during sleep

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- ❍ headache that disturbs sleep
- ❍ headache that does not disturb sleep
- ❍ snoring
- ❍ sleep apnoea
- ❍ frequent awakenings during the night (no. of awakenings: _______________)
- ❍ feeling unrefreshed in the morning
- ❍ daytime lethargy / sleepiness
- ❍ positive dream recollections (remembering dreams vividly)
- ❍ never / rarely remembers dreams
- ❍ headache present upon waking
- ❍ headache in the morning
- ❍ headache during the day
- ❍ headache in the evening

Usual sleep posture:

- ❍ back
- ❍ left side
- ❍ right side
- ❍ stomach
- ❍ toss and turns

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