Complete ONLY if you are being seen for headaches as a primary complaint

NAME: ____________________________

HEADACHE QUESTIONNAIRE

1 My headaches started on:

2 I get headaches about every: day / _____days a week/ _____days a month

3 My headache is accompanied by (circle):
light sensitivity noise sensitivity nausea vomiting dizziness numbness weakness
red tearing eye congestion visual changes confusion loss of consciousness neck stiffness

Preventative medications : medications taken on a daily basis to prevent the headache

Medication	Max dose and duration used / side effects	Did it help?
Beta blockers (proprenolol, inderol, metoprolol, etc.)		
Verapamil		
Amitriptyline (Elavil)		
Nortriptyline (Pamelor)		
Depakote (Valproic Acid)		
Topomax		
Lyrica		
Magnesium		
Butterburr		

Abortive medications : taken to get rid of a headache

Medication	Max dose and duration used / side effects	Did it help?
Tylenol		
Advil		
Excedrin Migraine		
Aleve/Naproxen		
Midrin/Epidrin		
Cafergot		
Fioricet / Fiorinal		
DHE / Migranal		
Triptans: (circle) Maxalt, Imitrex, Relpax,		
Narcotics: Percocet, Vicodin, Lortab,		
Steroids		

Have you tried any of these preventative procedures?

Procedure	How long used?	Did it help?
Botox Injections		
Trigger Point Injections		
Chiropractic Manipulation		
Physical Therapy		
Acupuncture		