Name: _____

Date: _____

HEADACHE HISTORY

Headache patients are not all the same, so in order to ensure we can provide you as accurate a diagnosis as we can, we would ask your assistance in filling out the following form as completely and as accurately as possible. For nearly all patients this will allow us to begin, on the initial visit, not only the process of getting any further necessary testing completed, but perhaps most importantly, it usually also allows us to begin or change treatment at that first visit.

Further, providing us copies of: (1) all of your prior neurological or headache specialist evaluations; (2) all of your actual radiological studies (on CD) and their corresponding reports; and (3) all of your relevant laboratory studies is required with your initial evaluation. Some patients find it helpful to include copies of their pharmacy records for the prior treatment of their headache, and this is very much appreciated, as well.

Not all questions may pertain to you. The more complete the information you provide on this form, the faster and better we can design your plan of care and thus optimize your time at your initial appointment. This is usually best accomplished by completing it prior to the initial evaluation, not in the waiting room in a hurry prior to being seen. If you have questions, please contact us so we can assist you.

As this is an extensive amount of information, we strongly recommend that you not wait until you arrive at the office to begin the process of filling out this Headache History form. If you prefer to do so, we recommend that you arrive at least an hour prior to your scheduled visit with all of your records to assist in this process. Again, however, we ask that you understand that we may have to reschedule your initial evaluation if these forms are not entirely completed in time for your scheduled initial appointment.

This form is in addition to the basic forms all new patients are asked to complete, as this one is only concerned with the symptom of headache.

We appreciate your time and effort in providing us an accurate, complete record of your headache history so we can be better prepared to help you!

_____

Reviewed by
Dr. Vaughan

Name: _____

Date: _____

At what age did you first start having headaches? _____

Does anyone else in your family have headaches? Y N Who?_____

How long was the longest headache you've had (treated or untreated)? _____

What is the longest period of time you have not had a headache for? _____

Currently, do you have a headache all of the time? Yes No

If so, how long have you "kept" this headache? _____

Does it feel like your "typical" headache, or is this one different? _____

Did this change from having episodic headaches occur suddenly or gradually?_____

If your headache isn't there all the time, over the last six (6) months please estimate on how many days per month you have had a headache: _____

Is your headache problem getting worse? Yes No

Are they becoming more frequent, more severe, lasting longer?_____

If your headache problem has changed, when exactly did that occur? _____

Please list if something occurred prior to this change in your headaches (e.g., an illness, an accident, a significant emotional event):_____

Do you often go to the emergency room/acute care facility for headache? Yes No

Have you ever been admitted to the hospital to treat your headache? Yes No

Have you ever seen a headache specialist? Yes No Who? _____

Do your headaches appear to be more prominent or only occur at certain times of the year?

_____

_____

Reviewed by
Dr. Vaughan

Name: _____

Date: _____

Do your headaches seem to occur at certain times of the day? _____

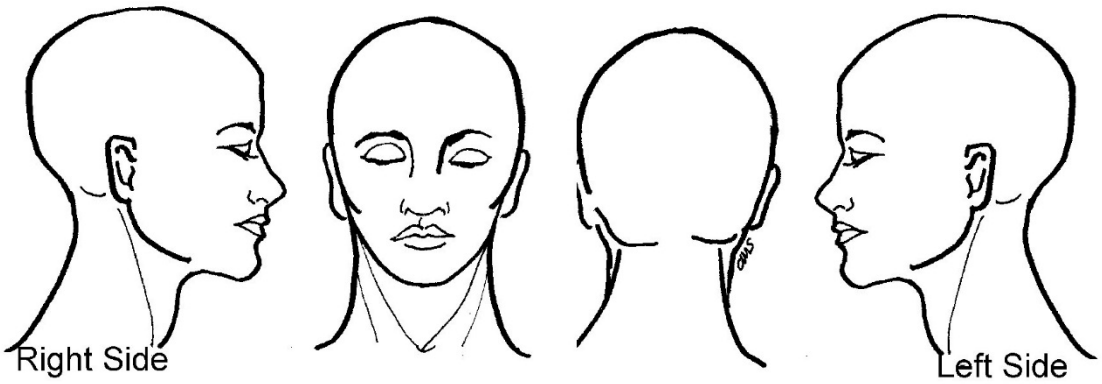
Do headaches wake you up in the middle of the night? Yes No

Do you commonly wake up at your normal time in the morning with a headache? Yes No

How long does it take for your headache to reach how bad it is going to get (in other words, how long is the build-up time for the pain) if you don't take any medication? _____

Where on your head does your headache typically start? _____

When fully developed, in the below diagram shade the part of the head involved in the pain:



Shade starting area and then complete headache involvement on these diagrams.

How bad is the pain typically (0 is no pain, 10 is the worst pain imaginable)? _____

Untreated, how long does the headache typically last? _____

What is the best way to describe the type of pain that the headache is?_____

_____

Does the pain you have with the headache throb? Yes No

_____
Reviewed by
Dr. Vaughan

Name: _____

Date: _____

Circle any of the below particular triggers which may seem to provoke your having a headache:

Allergies or sinusitis

Foods:

- tyramine (found in chocolate; aged cheeses; vinegar; organ meats; sour cream; soy sauce; yogurt; yeast extracts)
- nitrites (found in smoked fish; pepperoni; hot dogs; bologna; bacon; corned beef; pastrami; canned ham; sausages)
- sulfites; phenylethylalanine; tannins
- MSG (found in dry roasted nuts; potato chips; Chinese food; processed or frozen food; soups and sauces; diet foods; salad dressings; and mayonnaise)
- dehydration, fasting, or skipping meals
- alcohol (red wine; brandy; least likely—scotch, vodka, and Rieslings)
- vitamins (A and B, especially niacin)
- caffeine or not enough caffeine
- dairy products
- soy beans
- wheat products
- onions
- fatty foods
- seafood
- aspartame (Nutrasweet) or other artificial sweeteners
- beans; chiles; licorice; fried foods; peanuts; popcorn; nuts/seeds

Hormones:

- onset of your menstruation during your teenage years
- menstrual periods (or right before they start)
- time of ovulation (generally two weeks before your period starts)
- use of sex hormones/birth control pills/estrogen/progesterone/testosterone
- pregnancy or after pregnancy
- menopause/premenopause

Changes, such as:

- weather
- barometric pressure
- seasons
- travel, especially across time zones
- altitude
- schedule (e.g., work, sleep, meal times)
- sleeping patterns
- oversleeping
- undersleeping
- skipping meals
- fatigue
- riding in a car
- vacations

_____

Reviewed by
Dr. Vaughan

Name: _____

Date: _____

Sensory stimuli:

- strong lights
- glare
- flickering lights
- strong smells
- head jarring
- hunger
- position
- sexual activity
- sneezing
- straining

stress (or after stress is over)
touching
bending over
chewing
coughing
loud noises
reading in a car
lack of caffeine
eating cold foods/drinks ("ice cream headache")

Stress:

- intense emotional stress
- intense exercise
- changes in stress levels
- periods after stress has resolved
- relationship problems
- work-related problems

Is there anything you can do to make your headache less severe? _____

Is there anything you can do to make your headache go away? _____

Can you sleep off your headaches? Yes No

What do you typically do when you have a headache, especially a severe one? _____

_____

_____

_____

Reviewed by
Dr. Vaughan

Name: _____

Date: _____

Some patients can have symptoms which lead them to know that they're going to get a headache in a day or so, or their close family members or coworkers notice these and tell them so. Circle any of the below symptoms which could predict your having a headache in the next day or so:

mental slowness
depression
hyperactivity
fatigue
euphoria (intense happiness)
talkativeness
irritability
drowsiness
malaise/feeling bad
restlessness
surge of energy
light sensitivity
poor concentration
smell sensitivity
sound sensitivity
problems talking
sleep too much
yawning
muscle aches
hot ears
stiff neck
food cravings
cold feelings
loss/increase of appetite
sluggishness
diarrhea
constipation
nose bleed
thirst
urination
fluid retention

Just before having a headache, within a few hours of the head pain's starting, some headache patients have various symptoms. Circle if you have any of the below symptoms:

visual loss or changes
numbness
tingling
tunnel vision
vertigo
change/loss of smell
things look too large
seeing dots
dizziness
language problems
lightheadedness
hearing issues
things look too small
tongue numbness
seeing zigzag lines
tunnel vision
emotional changes
inspiration/other religious experience
change/loss of taste
touch sensitivity
lips numb/tingling

If so, how long does that above symptom last? _____

If it stops prior to the head pain, how long is that break in between?
_____

For visual symptoms, do you have them without ever developing the headache? Yes No

_____
Reviewed by
Dr. Vaughan

Name: _____

Date: _____

During the actual head pain itself, circle if you have any of the below symptoms:

loss of appetite
light and/or sound sensitivity
mood changes
concentration difficulties
diarrhea
feeling need to have a bowel movement
abdominal cramps
cold hands/feet
nasal congestion/drainage
runny eYes
change in pupil size
red eYes
eyelid swelling
droopy eyelid
facial swelling
amnesia/memory loss
blindness
problems talking
numbness
neck tenderness
nausea with or w/o vomiting
lightheadedness
visual blurring
excess hot or cold feelings
fluid retention
constipation
feeling poorly
loss of appetite
fever/chills
facial flushing
scalp tenderness
lack of coordination
irritability
loss of depth perception
uncontrolled bowels
neck pain
confusion
ear ringing
tingling
goose bumps
smell sensitivity
clumsiness
vertigo/room spinning
tremors
slurred speech
pale
double vision
weakness
excess urination
teeth grinding
fatigue
insomnia/poor sleep
visual loss
passing out
uncontrolled bladder
language problems
shoulder stiffness
hearing loss
"spacey" feeling
dizziness

Does the headache get worse with bending over, climbing stairs, walking? Yes No

Does having a headache keep you from doing your normal daily activities, working, or prevent your doing enjoyable activities? Yes No

When you don't have a headache, do you have:

spots or dots or temporary visual loss on standing up quickly? Yes No
excessive blurry vision? Yes No
double vision? Yes No
ringing in your ears? Yes No
does it throb with your pulse if you have it? Yes No
recent weight gain? Yes No
how much? _____

_____
Reviewed by
Dr. Vaughan

Name: _____

Date: _____

Do you have any of the following symptoms as new symptoms:

- does your headache come on or worsen dramatically on standing or sitting? Yes No
- does your headache start on getting out of bed and then worsen throughout the day? Yes No
- can you have little to no headache in the morning but every afternoon you develop a severe one? Yes No
- do you have any fluid leaking out of your ears or nose? Yes No
- do you have excessive postnasal drop which isn't related to allergies? Yes No
- did you have the sudden appearance of this headache? Yes No
- is this headache often very severe, nearly daily being very severe? Yes No
- are you much more fatigued since having this new headache? Yes No
- does your headache get better in a few minutes of laying down without going to sleep? Yes No
- do you have dizziness/lightheadedness/vertigo/imbalance generally since this headache started? Yes No
  - do you have more of these symptoms when the headache is worse? Yes No
- did you have any head or spine trauma prior to this new headache? Yes No
- do you have a new metallic taste in your mouth? Yes No
- do you now have significant neck pain or pain in the back of your head? Yes No
- has your hearing worsened since this headache started? Yes No
- is your hearing impaired (for example, muffled) when this headache is very severe? Yes No
- do you have any new ringing in your ears? Yes No
- when the headache is particularly severe, do you have any double vision? Yes No
- is there very prominent blurry vision with this headache? Yes No
- is there a family history of any of the following diseases:
  - Marfan's syndrome? Yes No
  - Ehlers-Danlos syndrome? Yes No
  - polycystic kidney disease? Yes No
  - neurofibromatosis? Yes No

- Do you have any facial pain or facial numbness with this headache? Yes No
- Are you clumsy with this headache? Yes No
- Newly diagnosed stroke? Yes No
- Any new slurred speech? Yes No
- Any new problems swallowing? Yes No
- Any new tremor? Yes No
- Any new neck, low back, or spine area pain? Yes No
- Any new arm or leg pain? Yes No

After the head pain is gone, do you have any of the following symptoms:

- changes in thirst? Yes No
- changes in appetite? Yes No
- head soreness or tenderness or sensitivity? Yes No
- trouble thinking? Yes No
- fatigue/drowsiness? Yes No
- feeling "hungover"? Yes No
- nausea? Yes No
- vomiting? Yes No
- diarrhea? Yes No
- constipation? Yes No
- weakness? Yes No
- mood changes? Yes No

_____

Reviewed by
Dr. Vaughan

Name: _____

Date: _____

Have you had any testing done for your headaches? **If no tests, please circle: No**
If yes, **please ensure we got a copy of the films themselves and the report from the radiologist who read the studies**. Examples include (circle if you've had that test):

MRI brain
MRI cervical spine
MR angiogram of neck/head
MR venogram of head

CT brain
CT sinuses

TMJ (temporomandibular joint) x-rays

Spinal tap/lumbar puncture
EEG
Sleep test
Ultrasound of carotid arteries
Echocardiogram

Have you ever had any significant head or neck trauma or a concussion? Yes No
If so, how many times? _____ and when was the last episode? _____

Do you have a history of heart problems or stroke(s)/mini-stroke(s)? Yes_____ No

Have you ever been diagnosed with "complicated migraine"? Yes No

Does anyone in your family have a history of heart problems (e.g., heart attack) prior to age 60?

Yes _____ No

Does anyone in your family have a history of stroke(s) or mini-stroke(s) prior to age 60?

Yes _____ No

Do you or does anyone in your family have a history of seizures or epilepsy (includes petit mal, grand mal, febrile [with a high fever])? Yes _____ No

Is there any pending legal action related to your headaches? Yes _____ No

_____
Reviewed by
Dr. Vaughan

Name: _____

Date: _____

Have you ever had any use or abuse of illicit drugs (including, but not limited to, marijuana, cocaine, heroin, crystal meth, Ecstasy)? Yes _____ No

Do you or does anyone in your family have a history of problems getting pregnant or a history of multiple miscarriages? Yes _____ No

Do you or does anyone in your family have a history of emotional/psychiatric problems, such as anxiety, depression? Yes _____ No

Do you or does anyone in your family have a history of:

fibromyalgia syndrome?	Yes	No
chronic widespread pain?	Yes	No
chronic fatigue syndrome?	Yes	No
interstitial cystitis?	Yes	No
IBS (inflammatory/irritable bowel disease)?	Yes	No
multiple chemical sensitivity syndrome?	Yes	No
idiopathic environmental intolerance syndrome?	Yes	No
chronic fatigue and immune dysfunction syndrome?	Yes	No
unrelenting fatigue?	Yes	No
myalgic encephalomyelitis?	Yes	No

Do you have any neck pain when you don't have a headache?	Yes	No
Do you have any low back pain when you don't have a headache?	Yes	No

_____

Reviewed by
Dr. Vaughan

Name: _____

Date: _____

If you don't feel rested on awakening in the mornings most of the time, please answer the following questions:

Do you wake up a lot at night not knowing why?	Yes No
Do you snore, or has someone told you that you snore?	Yes No
Do you have relatives who snore, especially snore loudly?	Yes No
Are you tired during the day most days?	Yes No
If you can nap, do you feel refreshed afterwards?	Yes No
Do you fall asleep quickly when you go to bed?	Yes No
If not, how long does it usually take you to fall asleep? _____ hours	
Do you have uncontrollable sleep attacks?	Yes No
Do you ever have spells of losing control over your muscles especially when crying or laughing hard?	Yes No
Do you have vivid dream-like visions on falling asleep or prior to waking up?	Yes No
Have you ever had sleep paralysis?	Yes No
Do you have a problem with losing control of your bowels or bladder when you're sleeping?	Yes No
Do you sleepwalk, or did you sleepwalk when younger?	Yes No
Do you commonly wake up with a headache?	Yes No
Do you commonly wake up with a sore throat?	Yes No
Do you have pain that keeps you from falling asleep or staying asleep?	Yes No
Do you have leg movements that keep you from falling asleep or staying asleep?	Yes No
Do you have, especially in the evenings, uncomfortable numb, tingly, creeping, or crawling sensations in your legs, which may be made less severe when you move your legs?	Yes No
Do you grind your teeth, especially when sleeping?	Yes No
Have you ever had TMJ/temporomandibular joint disorder?	Yes No
Has any regular bed partner ever complained about your sleep?	Yes No

If you drink caffeine daily, about how many servings? _____

Do you have environmental allergies ("hay fever"), allergic rhinitis? Yes No

Do you take any medications more than twice weekly to treat pain or headache, over-the-counter or prescription ones (including Tylenol, Advil, Motrin)? Yes No

Which one(s)? _____

How many times a day? _____

How many days in a week? _____

OTHER SYMPTOMS

_____

Reviewed by
Dr. Vaughan

Name: _____

Date: _____

lightheadedness/ dizziness: Yes No
poor equilibrium/imbalance: Yes No
exercise intolerance: Yes No
extreme fatigue: Yes No
weakness: Yes No
fainting: Yes No
excessive thirst: Yes No
blurry vision/different pupil sizes: Yes No

Any of the above eight symptoms provoked or worsened by:
heat exposure: Yes No
physical exertion: Yes No
heavy meals: Yes No
prolonged bedrest: Yes No
menses/periods: Yes No
drugs (especially blood pressure pills): Yes No

cold extremities (hands and feet): Yes No
disorientation/confusion: Yes No
hypertension (high blood pressure): Yes No
hypotension (low blood pressure): Yes No
variable blood pressure: Yes No
tinnitus (ringing in the ears): Yes No
shortness of breath: Yes No
headache: Yes No
muscle weakness: Yes No
fibromyalgia/chronic fatigue symptoms: Yes No
tremulousness/feeling of an internal tremor: Yes No
visual disturbances: Yes No

brain fog: Yes No
burnout, physical: Yes No
burnout, emotional: Yes No
decreased mental stamina: Yes No
depression: Yes No

_____
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difficulty finding the right word: Yes No
impaired concentration: Yes No
sleep disorders: Yes No
anxiety: Yes No and how severe (mild, moderate, severe): _____

heart rhythm problems: Yes No
palpitations (feeling of an irregular heartbeat): Yes No
heart attack: Yes No
chest pain/discomfort: Yes No

feelings of chills: Yes No
feelings of fear: Yes No
flushing/getting red in the face: Yes No
getting pale in the face: Yes No
overheating: Yes No
nervousness: Yes No
overstimulation: Yes No
noise sensitivity: Yes No
light sensitivity: Yes No

abdominal pain or discomfort: Yes No
bloating/excessive feeling of full stomach: Yes No
constipation: Yes No
diarrhea: Yes No
nausea: Yes No
vomiting: Yes No
excessive urination/other bladder problems: Yes No
loss of hunger sensation: Yes No
loss of sex drive: Yes No

A prior diagnosis of a small-fiber peripheral neuropathy ("small-fiber neuropathy"): Yes No
Any sensory symptoms (numbness, tingling, or pain): Yes No

restless legs syndrome diagnosis or symptoms: Yes No

Name: _____

Date: _____

dry mouth/eYes? Yes No
feet pale or blue? Yes No
feet colder than rest of body? Yes No
sweating in feet less than in rest of body? Yes No
sweating in feet decreased or absent, e.g., after exercise or during hot weather? Yes No
sweating in hands increased over rest of body? Yes No
nausea, vomiting, or bloating after eating a small meal? Yes No
persistent diarrhea (> 3 loose BM's daily)? Yes No
persistent constipation (< 1 BM qod)? Yes No
urinary leaking? Yes No

Prior diagnosis of:
"chronic fatigue syndrome (CFS)" Yes No
"fibromyalgia syndrome (FMS)" Yes No
"interstitial cystitis (IC)" Yes No
"irritable bowel syndrome (IBS)" Yes No
"multiple chemical sensitivity syndrome (MCS)" Yes No
"idiopathic environmental intolerance syndrome (IEI)" Yes No
"chronic fatigue and immune dysfunction syndrome (CFIDS)" Yes No
"unrelenting fatigue (UF)" Yes No
"myalgic encephalomyelitis (ME)" Yes No
"chronic widespread pain (CWP)" Yes No

Diagnosis of rheumatological/arthritis disease: Yes No
Diagnosis of Ehlers-Danlos syndrome/other joint hypermobility disorder: Yes No
Known viral illness before these symptoms started: Yes No
Closed head injury (CHI)/traumatic brain injury (TBI) history? Yes No

Date of last event of head trauma: _____
Total number of concussions: _____

Below symptoms as part of CHI/TBI diagnosis?
Headache (new or change in prior headache): Yes No
Nausea/vomiting: Yes No
Drowsiness: Yes No

_____
Reviewed by
Dr. Vaughan

Name: _____

Date: _____

Dizziness: Yes No
Fatigue: Yes No
Irritability: Yes No
Sensitivity to Noise: Yes No
Sensitivity to light: Yes No
Visual changes (blurry or double vision): Yes No
Tinnitus/ringing in ears: Yes No
Hearing loss: Yes No
Decrease in smell and/or taste: Yes No
Sleep problems especially problems falling asleep: Yes No
Poor concentration: Yes No
Memory problems: Yes No
Unable to tolerate stress: Yes No
Unable to tolerate alcohol intake: Yes No
Changes in how you look (look sad, depressed): Yes No
Increased/new anxiety: Yes No
Increased/new depression: Yes No
Personality changes: Yes No
Apathy/loss of interest in daily life: Yes No
Poor judgment: Yes No
Restlessness: Yes No
Aggression: Yes No
Mood swings: Yes No
Anger: Yes No
Decreased or lost sex drive: Yes No

Family history of similar symptoms to yours? Yes No

_____
Reviewed by
Dr. Vaughan

Name: _____

Date: _____

How oft

sensation o

16

_____
Reviewed by
Dr. Vaughan

Name: _____

Date: _____

Instructions to patient: "Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then fill in the circle of the response to indicate how much you have been bothered by that problem **IN THE PAST MONTH**." Please fill in ONE option only for each question."

	Response	**Not at all (1)**	**A little bit (2)**	**Moderate (3)**	**Quite a bit (4)**	**Extreme (5)**
1.	Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because *they remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

_____
Reviewed by
Dr. Vaughan

Name: _____

Date: _____

How often over the last 2 weeks have the below bothered you?	Not at all	Several days	➢ Half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
□	□	□	□

_____
Reviewed by
Dr. Vaughan

Name: _____

Date: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score: = Add Columns _____ + _____+ _____

= _____ **(total score)**

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all _____

Somewhat difficult _____

Very difficult _____

Extremely Difficult _____

_____
Reviewed by
Dr. Vaughan

Name: _____

Date: _____

Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your healthcare professional.

1. On how many days in the last 3 months did you miss work or school because of your headaches?

   _____

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.)

   _____

3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

   _____

4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

   _____

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

   _____

Total (add all of the answers to questions 1-5) : _____

What your Physician will need to know about your headache:

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

   _____

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

   _____

_____

Reviewed by
Dr. Vaughan

Name: _____

Date: _____

Use the following scale to choose the most appropriate number for each situation:
0 = would *never* doze or sleep during that activity
1 = *slight* chance of dozing or sleeping during that activity
2 = *moderate* chance of dozing or sleeping during that activity
3 = *high* chance of dozing or sleeping during that activity

SITUATION	**CHANCE OF SLEEPING**
Sitting and reading	____
Watching TV	____
Sitting inactive in a public place	____
Being a passenger in a motor vehicle for an hour or more	____
Lying down in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in traffic while driving	____
Total score (add the scores up)	____

_____
Reviewed by
Dr. Vaughan

Name: _____

Date: _____

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE	

_____

_____

Reviewed by
Dr. Vaughan

Name: _____

Date: _____

I have pain all over my body.	Yes	No
My pain is accompanied by a continuous and very unpleasant general fatigue.	Yes	No
My pain feels like burns, electric shocks, or cramps.	Yes	No
My pain is accompanied by other unusual sensations throughout my body, such as pins and needles, tingling, or numbness.	Yes	No
My pain is accompanied by other health problems such as digestive problems, urinary problems, headaches, or restless legs.	Yes	No
My pain has a significant impact on my life, particularly on my sleep and my ability to concentrate, making me feel slower generally.	Yes	No

_____

Reviewed by
Dr. Vaughan

Name: _____

Date: _____

When you have headaches, how often is the pain severe?

Never Rarely Sometimes Very Often Always

How often do headaches limit your ability to do usual daily activities, including household work, work, school, or social activities?

Never Rarely Sometimes Very Often Always

When you have a headache, how often do you wish you could lie down?

Never Rarely Sometimes Very Often Always

In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

Never Rarely Sometimes Very Often Always

In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

Never Rarely Sometimes Very Often Always

In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

Never Rarely Sometimes Very Often Always
0

Column _____ _____ _____ _____ _____
Totals

_____
Reviewed by
Dr. Vaughan

Name: _____

Date: _____

_____
Reviewed by
Dr. Vaughan