HPCS

Headache History Form

Date:________________

• Who is your current treating physician? ______________________________________
____

• How many headaches do you experience per month on average?
____

• How painful are is your average headache? (circle one number)

1 2 3 4 5 6 7 8 9 10
Mild Severe

• How long do your headaches usually last?
____

• When do your headaches usually start?
morning afternoon evening night

• Where are your headaches usually located? (circle all that apply)

behind right eye	behind left eye	behind both eyes
right temple	left temple	both temples
above right eyebrow	above left eyebrow	above both eyebrows
back of head on right	back of head on left	back of head both sides

• How old were you when your headaches started?
____

• How would you describe your headaches? (circle all that apply)
throbbing/pounding ache/pressure like a tight band
other (please describe): _______________________________________

• Do your headaches awaken you at night? (check one)
never occasionally often

Headache History Form

Date:________________

• Do any of the following occur before/during your headaches? (circle all that apply)

nausea/vomiting | runny nose | bothered by light/noise
blurry/double vision | flashing/colored lights | puffy/droopy eyelids
other _________________________________

• Do any of the following bring on your headaches or make them worse?

stress | bright lights | weather changes
loud noise(s) | heavy lifting | fatigue
exercise
other _________________________________

• Do any of the following make your headaches better? (circle all that apply)

rest | exercise | quiet/darkness
pressure on head | massage | vomiting
hot or cold compresses
other _________________________________

• Do you have any areas that are tender either before, during, or after a headache? (circle all that apply)

above the eyebrows | the temple | in front or behind the ears
the back of the neck | the bridge of the nose

• Does pressure or massage on the following areas reduce or eliminate the headache pain? (circle all that apply)

above the eyebrows | the temple | in front of or behind the ears
the back of the neck | the bridge of the nose

• If you are female, do your headaches change with any of the following?

menstrual periods/pregnancy | birth control pills/ other hormones

Headache History Form

Date:________________

- Have you ever had a head or a neck injury requiring medical treatment?

  no yes

  If yes, describe ____

- Have you had your headaches evaluated by a neurologist?

  no yes

  If yes, by whom and when _________________________________

- What was the diagnosis? (check all that apply)

  migraine tension-type cluster occipital neuralgia

  other (specify) ________________________

- List all past tests you had for your headaches:

  ____

  ____

- List all past headache treatment(s) and medications:

  ____

  ____

- List all current headache medications:

  ____

  ____

- To what extent do your headaches affect your quality of life? (check one)

  extremely moderately very little none at all

- What activities in life have you given up because of your headaches? ________________

  ____