

# HEADACHE PATIENT QUESTIONNAIRE & EVALUATION

## SECTION 1

1. Have you ever experienced headaches with any two of the four following features?

- throbbing or pounding pain
- pain worse on one side of the head
- pain accompanied by nausea
- light or sound sensitivity

YES  NO

If you answered "yes," complete questions 2 through 15.  
If you answered "no," skip to question 16.

2. I have had at least 5 headaches of this type in the past.

YES  NO

3. When I have this type of headache the pain lasts for 4 to 72 hours if I don't take any medication.

YES  NO

4. When I have this type of headache, I have experienced blind spots, blurred vision, flashing of shimmering lights, or zigzag lines prior to the onset of headache pain.

YES  NO

5. When I have this type of headache the pain is usually throbbing or pounding.

YES  NO

6. When I have this type of headache the pain is usually on one side of my head.

YES  NO

7. When I have this type of headache I often feel nauseous.

YES  NO

8. When I have this type of headache I have vomited on occasion.

YES  NO

9. When I have this type of headache I am often sensitive to light.

YES  NO

10. When I have this type of headache I am often sensitive to noise.

YES  NO

11. When I have this type of headache, any kind of physical activity--such as climbing stairs--can make it worse.

YES  NO

12. When I have this type of headache I have missed work or have not been able to perform to my usual standards.

YES  NO

13. The occurrence of these headaches often coincides with a particular time period during my menstrual cycle (women only).

YES  NO

14. Approximately how long have you been suffering with this type of headache?

\_\_\_\_\_ year(s)

15. On average, how frequently do you experience this type of headache each month?

\_\_\_\_\_ episode(s) per month

## SECTION 2

16. Have you ever experienced headaches with any of the following features?

- pain that is a dull ache or a bandlike pressure that feels like a tightening or squeezing
- pain that is felt all around the head
- pain that lasts from 30 min to 7 days (without medication)
- headaches that occur suddenly or daily

YES  NO

If you answered "yes," complete questions 17 through 9.  
If you answered "no," skip to the end for evaluation.

17. I have had at least 10 headaches of this type in the past.

YES  NO

18. When I have this type of headache the pain lasts for 30 min or more if I don't take any medication.

YES  NO

19. When I have this type of headache the pain is usually a dull, oppressive ache or feels like a vice-grip tightening around my head.

YES  NO

20. When I have this type of headache the pain is usually felt throughout my whole head.

YES  NO

21. When I have this type of headache I sometimes feel a tightness or stiffness in my neck.

YES  NO

22. When I have this type of headache, I can usually still perform normal daily activities such as climbing stairs.

YES  NO

23. I usually do not miss work because of this type of headache.

YES  NO

24. When I have this type of headache I often feel nauseous.

YES  NO

25. When I have this type of headache I have vomited on occasion.

YES  NO

26. When I have this type of headache I am often sensitive to light.

YES  NO

27. When I have this type of headache I am often sensitive to noise.

YES  NO

28. Approximately how long have you been suffering with this type of headache?

\_\_\_\_\_ year(s)

29. On average, how frequently do you experience this type of headache?

\_\_\_\_\_ day(s) per month

Proceed to evaluation section of questionnaire -->

## EVALUATION

Tally your answers for the following questions (Q) in each section.

### Section 1

Q1 \_\_\_ YES , \_\_\_ NO  
Q2 \_\_\_ YES , \_\_\_ NO  
Q3 \_\_\_ YES , \_\_\_ NO  
Q4-13 total number YES \_\_\_  
Q14 \_\_\_ year(s)  
Q15 \_\_\_ episode(s)

### Section 2

Q16 \_\_\_ YES , \_\_\_ NO  
Q17 \_\_\_ YES , \_\_\_ NO  
Q18 \_\_\_ YES , \_\_\_ NO  
Q19-23 total number YES \_\_\_  
Q24-27 total number NO \_\_\_  
Q28 \_\_\_ year(s)  
Q29 \_\_\_ day(s)

If you answered "yes" to questions 1-3 and totaled at least 4 "yes" responses to questions 4-13, consult with your doctor to see if you are suffering from MIGRAINE.

If you answered at least "1 year" to question 14 and at least "1 episode" to question 15, consult with your doctor to see if you are suffering from MODERATE-TO-SEVERE MIGRAINE.

If you answered "yes" to questions 16-18, totaled at least 3 "yes" responses to questions 19-23, and totaled at least 3 "no" responses to questions 24-27, consult with your doctor to see if you are suffering from TENSION-TYPE HEADACHE.

If you answered at least "one-half year" (6 months) to question 28 and at least "15 days" to question 29, consult your doctor to see if you are suffering from CHRONIC TENSION-TYPE HEADACHE.

If your scores qualified you to be suffering from both migraine and tension-type headache, consult with your doctor to see if you are characterized as having MIXED HEADACHE SYNDROME.

This questionnaire does not provide a conclusive headache diagnosis. A true differential diagnosis can only be made by your doctor after a thorough physical examination and more extensive consultation with you. Differentiating between various types of headaches is important in order to specify the most effective treatment programs.

Please be sure to discuss this with your doctor.