

Headache Diagnosis and Management Guideline

Date: _____

Patient's name: _____ Age: _____

How long have you been suffering with headaches? _____

How old were you when the headaches began? _____

Do you know when a headache is coming on – Aura? _____

How often do you get a headache? _____

Please describe any aggravating or precipitating factors: _____

How long do the headaches last? _____

Where is the pain located? _____

Describe the pain: _____

On a scale of 1 – 5 how strong is the pain? _____

Are there any other symptoms? _____

Are there any visual symptoms? _____

Previous medications tried: _____

Previous diagnostic studies: _____

Family history of headaches: _____

Impact of headaches–how does it disrupt your life? _____

Are the headaches disabling? _____

Current treatment, if any: _____