

**HEADACHE MEDICINE**  
**NEW PATIENT QUESTIONNAIRE**

Name \_\_\_\_\_

Date \_\_\_\_\_

Age your headaches began \_\_\_\_\_ (or how long ago did they start? \_\_\_\_\_)

Do you have more than one type of headache?  Yes  No

*If yes, answer the following questions about your most disabling headache type.*

What parts of your head and neck hurt? \_\_\_\_\_

What does it feel like (aching, throbbing, etc)? \_\_\_\_\_

How often do your headaches occur? \_\_\_\_\_

How long do they last? On average \_\_\_\_\_ Longest \_\_\_\_\_ Shortest \_\_\_\_\_

How severe is your pain? Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_

Do you have any warning before the pain starts (aura)?  Yes  No

*If yes, describe* \_\_\_\_\_

Do you have any of the following with your headaches (check all that apply):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Nausea or inability to eat | <input type="checkbox"/> Worsening with activity (walking, climbing stairs) |   |
| <input type="checkbox"/> Vomiting                   | <input type="checkbox"/> Numbness or tingling                               |   |
| <input type="checkbox"/> Sensitivity to light       | <input type="checkbox"/> Weakness on one side of the body/face              |   |
| <input type="checkbox"/> Sensitivity to noise       | <input type="checkbox"/> Difficulty speaking                                | <input type="checkbox"/> Imbalance          |
| <input type="checkbox"/> Sensitivity to odors       | <input type="checkbox"/> Confusion  | <input type="checkbox"/> Spinning dizziness |
| <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Tearing from the eye(s)                            | <input type="checkbox"/> Double vision      |
| <input type="checkbox"/> Stuffy nose                | <input type="checkbox"/> Bloodshot eye(s)                                   | <input type="checkbox"/> Droopy eyelid      |
| <input type="checkbox"/> Runny nose                 | <input type="checkbox"/> Agitation  | <input type="checkbox"/> Other _____        |

Do your headaches ever awaken you from sleep?  Yes  No

Do you have to/prefer to lie down with your headaches?  Yes  No

Have you identified anything that triggers your headaches?  Yes  No

*If yes, list:* \_\_\_\_\_

Have your headaches caused problems in any of the following areas of your life?

- Job  Housework  School  Home life  Relationships  Social life  Legal

Describe: \_\_\_\_\_

Women: Do any of the following affect your headaches?  Ovulation  Menstrual period  IUD

Birth control pill  pregnancy  menopause Explain: \_\_\_\_\_

Have you had a brain CT or MRI?  Yes  No (*If yes, bring films or CD with you*)



ALLODYNIA QUESTIONNAIRE (ASC-12)					
How often do you experience increased pain or an unpleasant sensation on your skin during your most severe type of headache when you engage in each of the following?	Does not apply to me	Never	Rarely	Less than half the time	Half of the time or more
	Score: 0	Score: 0	Score: 0	Score: 1	Score: 2
Combing your hair					
Pulling your hair back (e.g., ponytail)					
Shaving your face					
Wearing eyeglasses					
Wearing contact lenses					
Wearing earrings					
Wearing a necklace					
Wearing tight clothing					
Taking a shower (when the water hits your face)					
Resting your face or head on a pillow					
Exposure to heat (e.g., cooking, washing your face with hot water)					
Exposure to cold (e.g., using an ice pack, washing your face with cold water)					
<b>Total Score</b>					
<b>Sum of total scores</b>					

Score: 0-2 none, 3-5 mild, 6-8 moderate, 9+ severe allodynia

### MIDAS DISABILITY ASSESSMENT

*This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you.*

**INSTRUCTIONS:** Please answer the following questions about all your headaches over the last **3 months**. Write your answer in the box next to each question. Write zero if you did not do the activity in the past **3 months**.

	<b>DAYS</b>
1. On how many days in the last 3 months did you miss work or school because of your headaches? (If you did not attend work or school enter zero in the box.)	
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. If you do not attend work or school enter zero in the box.)	
3. On how many days in the last 3 months did you not do household work because of your headaches?	
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days 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?	
<b>TOTAL (Questions 1-5)</b>	
A. On how many days in the last 3 months did you have a headache? (If headache lasted more than one day, count each day.)	
B. On a scale of 0-10, on average, how painful were these headaches? (Where 0=no pain at all, and 10=pain which is as bad as it can be.)	

Score: 0-5 Little to none, 6-10 mild, 11-20 moderate, 21+ severe disability