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YOUR HEADACHE HISTORY*

Name: ________________________________ **Age:** ____________ **Date:** ____________

Directions: By completing this headache history, you will help the doctor diagnose your headache condition and find the best treatment for you. Use the chart below to describe your headache(s). Some people experience different types of headaches. For example, one person might suffer from a dull, gnawing headache almost every day, but also have a severely painful headache a couple of times a month. The chart on this page gives you space to describe each type of headache you may have in detail. How many days in a month do you have headaches? ________________

	HEADACHE TYPE #1	HEADACHE TYPE #2	HEADACHE TYPE #3
How bad does your headache pain usually get, on a scale of 1 to 3? 1 = mild/dull; 2 = moderate; 3 = severe or unbearable	Circle the number that describes your pain: 1 2 3	Circle the number that describes your pain: 1 2 3	Circle the number that describes your pain: 1 2 3
How do your headaches affect your regular activities?	☐ No effect on my activities ☐ I carry out my activities fairly well ☐ I cut out all but the most important activities ☐ I miss work or stay in bed	☐ No effect on my activities ☐ I carry out my activities fairly well ☐ I cut out all but the most important activities ☐ I miss work or stay in bed	☐ No effect on my activities ☐ I carry out my activities fairly well ☐ I cut out all but the most important activities ☐ I miss work or stay in bed
When did you first start getting these headaches?			
How often did you have these headaches when they *first* began?			
How often do you have these headaches *now*?			
How long does your headache pain usually last?	____minutes ____hours _____days _____weeks	____minutes ____hours _____days _____weeks	____minutes ____hours _____days _____weeks
Where does your head hurt? (Check all that apply)	☐ Left side _ Right side ☐ All over _ It changes ☐ Front, forehead, face, jaw ☐ Back or near the neck ☐ Other	☐ Left side _ Right side ☐ All over _ It changes ☐ Front, forehead, face, jaw ☐ Back or near the neck ☐ Other	☐ Left side _ Right side ☐ All over _ It changes ☐ Front, forehead, face, jaw ☐ Back or near the neck ☐ Other
Describe the type of pain you have? (Check all that apply)	☐ Sharp ☐ Dull ache ☐ Stabbing ☐ Burning ☐ Squeezing ☐ Pressure ☐ Throbbing ☐ Pounding	☐ Sharp ☐ Dull ache ☐ Stabbing ☐ Burning ☐ Squeezing ☐ Pressure ☐ Throbbing ☐ Pounding	☐ Sharp ☐ Dull ache ☐ Stabbing ☐ Burning ☐ Squeezing ☐ Pressure ☐ Throbbing ☐ Pounding
What other symptoms do you get with your headaches? (Check all that apply)	☐ None ☐ I vomit ☐ I'm bothered by light ☐ I'm bothered by noise ☐ I have nausea or no appetite ☐ I feel cold ☐ I have difficulty thinking ☐ I feel dizzy ☐ Other ______________	☐ None ☐ I vomit ☐ I'm bothered by light ☐ I'm bothered by noise ☐ I have nausea or no appetite ☐ I feel cold ☐ I have difficulty thinking ☐ I feel dizzy ☐ Other ______________	☐ None ☐ I vomit ☐ I'm bothered by light ☐ I'm bothered by noise ☐ I have nausea or no appetite ☐ I feel cold ☐ I have difficulty thinking ☐ I feel dizzy ☐ Other ______________
Do you notice any visual changes (zigzag lines, flashing lights) at the time of your headache?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does your headache pain get worse with any kind of physical activity such as climbing stairs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*Adapted with permission from The New England Center for Headache, Stamford, CT May be reproduced for educational and patient purposes only.

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YOUR HEADACHE HISTORY* (continued)

CURRENT MEDICINES Please list all of the medicines you are now taking (headache and other medicines). **Include over-the-counter pain relievers.**

Name of medicine	#mg/ dose)	How taken	times taken/ day	Date started	Amount of relief *	Problems you have with the medicine (i.e., side effects)

*** 0 = no relief 1 = mild relief 2 = moderate relief 3 = complete relief D/A = doesn't apply**

PAST MEDICINES Please list all of the medicines you have taken in the past for your headaches. **Include over-the-counter pain relievers.**

Name of medicine	#mg/ dose)	How taken	times taken/ day	Date started	Amount of relief *	Problems you have with the medicine (i.e., side effects)

*** 0 = no relief 1 = mild relief 2 = moderate relief 3 = complete relief D/A = doesn't apply**

HEADACHE TRIGGERS Please check any of the following you feel may "trigger" or start your headaches:

- ☐ Alcohol
- ☐ Fasting
- ☐ Foods (list):
- ☐ Odors
- ☐ Bright lights
- ☐ Sun
- ☐ Seasonal changes
- ☐ Weather changes
- ☐ Altitude changes
- ☐ Lack of sleep
- ☐ Too much sleep
- ☐ Changes in usual sleep pattern
- ☐ Exertion (such as walking up stairs)
- ☐ Menstrual period
- ☐ Stress
- ☐ Vacations
- ☐ Weekends
- ☐ Let-down periods (following big events)
- ☐ Allergies or sinus problems
- ☐ Other:

YOUR FAMILY HISTORY

Does anyone in your family experience troublesome or disabling headaches? If so, who, and what kind of headaches?
____

Has anyone in your family had seizures, stroke, or any similar problems? ____

Does anyone in your family have heart problems, mental illness, or allergies? If so, who, and what kind of problem?____________________
____

Women: At what age did your mother go into menopause? ____

YOUR LIFESTYLE HABITS

Do you smoke? ☐Yes ☐No, If Yes, how many packs per day? _______ For how many years?_________
Do you drink alcohol? ☐Yes ☐No, If Yes, how often? ☐Daily, ☐1-2 times per week, ☐Occasionally, ☐Rarely
Do you drink coffee, tea, or caffeinated sodas? ☐Yes ☐No, What do you drink, and how much? _________
Do you eat foods or drink beverages that contain artificial sweeteners? ☐Yes ☐No, If Yes, what and how much?
Do you take any vitamin, mineral, or herbal supplements? ☐Yes ☐No, If Yes, please describe.
How well do you sleep?

PREVIOUS MEDICAL CARE

Have you ever visited a doctor for headaches? ☐Yes ☐No, If Yes, who was your doctor? ____________________
Describe any medical tests you've had for your headaches and the test results:

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