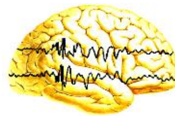
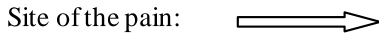
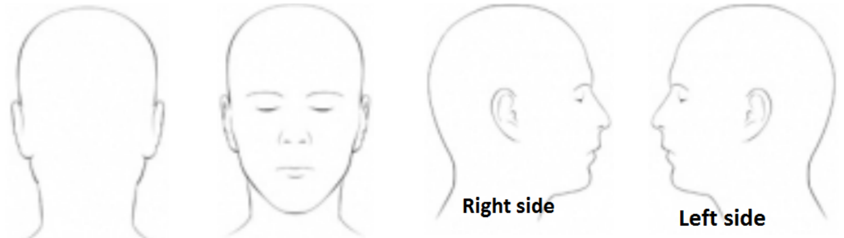


Dr. Hemang Shah, MD
Headache Questionnaire

When did your headache first start? _______________

How many **types** of headaches you have? ___________

Site of the pain: 



Type of pain: (circle) Pounding, squeezing, throbbing, dull aching, tightness, constant, pressure, stabbing, exploding, imploding, burning, lancinating, electric, spasms, pain behind eyes
____

Can you tell that you are about to get a headache? How? (Aura) ____

How long it takes for headache to reach its worst since onset of headache? ____________________________________

Typically, how long does your headache last? ____

Typically, how frequent do you have headaches? ____

My headache is associated with (circle) Nausea, Vomiting, Light sensitivity, Noise sensitivity, Irritability, Worsening with physical activity, Menstrual cycle (female), Numbness, Runny nose/eyes Sneezing, one sided weakness

What triggers (precipitates) your headache? ____

What makes the headaches better? Sleep / dark quiet room/____

Have you ever been on a medication every day to prevent headaches? If so, what was it? __________________________
____

What medicines have you tried to stop a headache? (Prescribed and over the counter) and how often you take them?
For e.g. Excedrin Migraine 1 pill 2 times a day ____

____

What type of work up has been done so far for evaluation of your headache? (E.g. CT head, MRI brain etc) {If you had previous brain scan done – it is very important to bring them for your clinic visit, radiology report is not enough} ___________________
____

Which other doctors you have seen for your headache? ____

Have you gone to emergency room with your headache? (If yes, how often and when): ______________________________

Do you suffer from depression? _________________________ Do you suffer from Obstructive Sleep Apnea? _________

Do you suffer from anxiety? ____________________________ Are you overweight or obese? _______________________

Have you ever had significant head trauma? ______________ Involved in any legal matter due to medical condition? __

Have you ever been involved in any type of abuse? Yes No I will talk to physician personally

Anybody in your family has headaches (If yes, whom) ____

More information you would like to provide about your headache? ____

Patient Name: ____ DOB: ___________________

TMJ myofascial refraction BP hormonal