IslandHealth
Committed to Patient Care Since 1894

HEADACHE CLINIC PRE-ASSESSMENT FORM

Dr Michael Long BMBS MRCGP DRCOG MSc (Headache Disorders)

enquiries@health.gg Dr Long's PA (01481) 245915

Prior to your detailed headache assessment with Dr Long it would be very helpful if you could complete the following pre-assessment questionnaire. This questionnaire has been specifically created to aid in the diagnosis of headache disorders, ensuring the clinician has the maximal amount of information to optimise diagnosis and ongoing treatment.

This questionnaire has been designed to be completed as easily as possible using a computer or a mobile device. It can then easily be emailed to enquiries@health.gg
However, if this is not possible then please print it out to complete it. You can either return it to Dr Long's PA or bring it with you to your consultation.

TO ELECTRONICALLY COMPLETE THE QUESTIONNAIRE

1. Save this document locally on your Computer or Mobile Device, making note of its location. On Apple devices when the file is open click the bottom left icon (pictured) and select save to files.

2. Ensure that you have dowloaded and installed Adobe Acrobat Reader on your Computer or Mobile Device. If this is a fresh install you can reject creating an account and click 'maybe later' until you reach the home page.

3. Open the file with Adobe Acrobat reader on your Computer or Mobile Device. On Computer right click and select open with Adobe Acrobat. On the mobile app select 'files', and location. If on Apple files you will need to select 'Browse more files' to access iCloud files.

4. Once the file is open you will need to select 'Fill and Sign'. On a Computer you will find this in the scrolling menu to the right side of the screen. On the Mobile app you can select the circle with a pen on the bottom right.

5. The questionnaire has been created with as many tick boxes as possible for ease. It can be completed using the tick tool for the boxes and the type tool where a more specific answer is required.

6. Once the questionnaire has been completed the file will need to be saved with your answers, re-named with you name, and sent back in an email. You may be able to send easily by clicking on the email icon. If not, to save the document without creating an account:

On a Computer: On the top bar which shows the fill and sign menu click the button that says 'close'. On the top menu bar, click 'file', then 'save as' and change the file name. Save the file on your desktop , or somewhere easy to find.

On the Mobile app: Click the ... in the top right corner of the screen. Scroll down to save a copy, this will open 'Save a copy to...' and select either 'On this [iPhone]' or another location of your choice which can be found easily. Please re-name the file before returning.

7. Open your emails on your Computer or Mobile Device and click add attachment, this is generally a icon of a paperclip. Select the saved document and return to the required recipient.

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PERSONAL INFORMATION

Full Name _____

Date of Birth ____ ____ ____ ____ ____ ____ ____ ____
D D M M Y Y Y Y

Surgery IslandHealth ○ Queens Road ○ Healthcare Group ○

GP _____

Date ____ ____ ____ ____ ____ ____ ____ ____
D D M M Y Y Y Y

HEADACHE HISTORY

How would you rate your mood in General? Excellent ○ Good ○ Neutral ○ Sad ○ Depressed ○

How is your sleep? Good ○ Difficulty falling asleep ○ Difficulty maintaining sleep ○

Do you snore at night? Yes ○ No ○

Has anyone ever told you you stop breathing at night? Yes ○ No ○

Do you suffer from travel sickness? Yes ○ No ○

Is there a family history of headaches? Yes ○ No ○

Relationship? _____

Did you suffer from headaches or reccurent abdominal pain when you were younger?

As a child ○ As a teenager ○ As a young adult 20's - 40's ○

Any comments _____

When did your current headache problems begin, or become a problem? ____ Months, ____ Years ago.

Lifestyle & Routine

What time do you wake up? _____ **Go to sleep?** _____

Is this the same time every day? Yes ○ No ○

Do you eat breakfast? Yes ○ No ○

Do you eat regular meals throughout the day? Yes ○ No ○

Do you skip meals? Yes ○ No ○ **Do you have snacks between meals?** Yes ○ No ○

What time do you eat? Breakfast _____ Lunch _____ Dinner/Supper _____

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HEADACHE HISTORY CONTINUED

On average how much caffeine do you consume daily? (# of drinks per day)

Coffee _____ Tea _____ Soft drinks _____

How much alcohol do you drink on average?

Drinks per day _____ per week _____ per month _____

Do you smoke? Yes ○ No ○ **If yes**, how many per day? _____ **If applicable,** when did you quit? _____

Do you do any regular exercise? Yes ○ No ○

Describe _____

Headache Characteristics

Do you notice any specific triggers for your headaches?

Alcohol ○ Food ○ Exercise ○ Coughing ○

Other _____

How many headache free days do you have per month? _____

On average, how often do you have a headache? _____ Times, **Per:** Day ○ Week ○ Month ○

Are the headaches increasing in frequency? Yes ○ No ○

Do the headaches begin Gradually ○ Suddenly ○ Varies ○

Do the headaches usually begin in the Morning ○ Afternoon ○ Evening ○ Night ○

Do you wake up with a headache in the morning? Yes ○ No ○

How long before the headaches reach maximal intensity? _____ Minutes _____ Hours

Headaches usually last (without medication) _____ Minutes _____ Hours _____ Days

(with medication) _____ Minutes _____ Hours _____ Days

How bad are your headaches? On a scale of 1-10, with 0 = no pain and 10 = worst pain imaginable

How do you rate your headaches on your: Best day _____ /10 Worst day _____ /10

What best describes the quality of your headache? (tick all that apply)

Throbbing ○ Stabbing ○ Pressure ○ Aching ○

Where do you experience the pain? (tick all that apply)

Face ○ Head ○ Neck ○ Other ○ Both sides ○ Left ○ Right ○

Describe _____

When you have headache do you have Nausea ○ Vomiting ○

When you have headache would you prefer to avoid Bright Lights ○ Loud Noises ○

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HEADACHE HISTORY CONTINUED

Would you prefer to lie down when you get your headaches? Yes ○ No ○

Do you experience other symptoms such as (tick all that apply)

Vision problems ○ Speech troubles ○ Numbness or tingling ○ Swallowing difficulties ○

Dizziness ○ Poor balance ○ Coordination Difficulties ○

What makes your headadches better? Rest ○ Medications ○ Exercise ○

Other _____

How long does your average headache last? _____

Please tick if you have been experiencing any of the following

Change in bowel or bladder function ○ Numbness or tingling in your legs ○ Loss of balance or coordination ○

Changes in speech or swallowing ○ Loss or change in vision ○ Loss of hearing ○

Night pain ○ Weight loss ○ Dizziness ○

Chills ○ Fever ○

MEDICATION HISTORY

If known, have you had any relevant tests? X-Ray ○ CT ○ MRI ○

Details _____

Current Medications _____

_____

Medication Allergies _____

Acute Medication

Medication	Dose	Duration	Benefit?	Side Effects?
Paracetamol				
Aspirin				
Ibuprofen				
Naproxen				
Codeine				
Migraleve				
Triptan				
Other:				

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MEDICATION HISTORY CONTINUED

Preventative Medication

Medication	Dose	Duration	Benefit?	Side Effects?
Propranolol				
Amitriptyline				
Nortriptyline				
Topiramate				
Candesartan				
Pizotifen				
Botox				
GON block				
Other:				

Supplements

Supplements	Dose	Duration	Benefit?	Side Effects?
Magnesium				
Vitamin B2				
Co-Enzyme Q10				
Vitamin D				
Omega 3				
Vitamin E				
Other:				

Note: This form has been designed to assist in a complete headache history. It is not intended to replace a face-to-face consultation.

This questionnaire may be retained as part of your medical history, in accordance with data protection laws.

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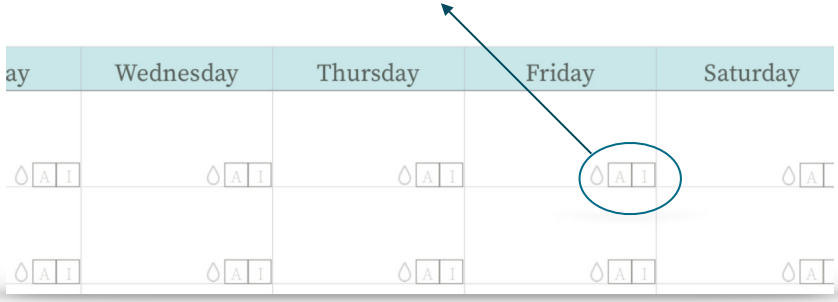
How to use the Migraine Diary

On the **monthly pages** there are boxes in the bottom right corner of each day. To indicate a menstrual period, colour in or highlight the droplet icon. Next to that you will see two small boxes containing the letters A & I.

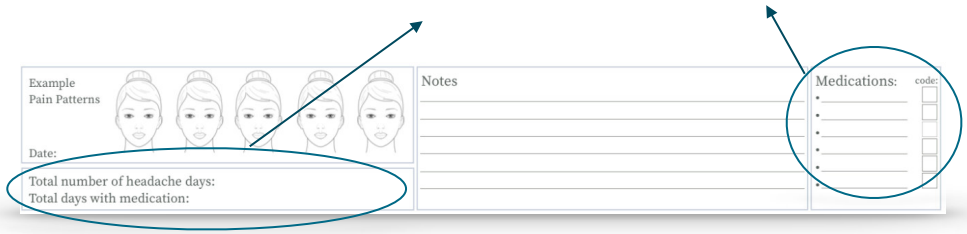
A is for Attack - this box you can just colour in or tick to indicate that you suffered an attack on this day.

I is for Intensity – in this box you should write or type the intensity of your attack, between 1-10.

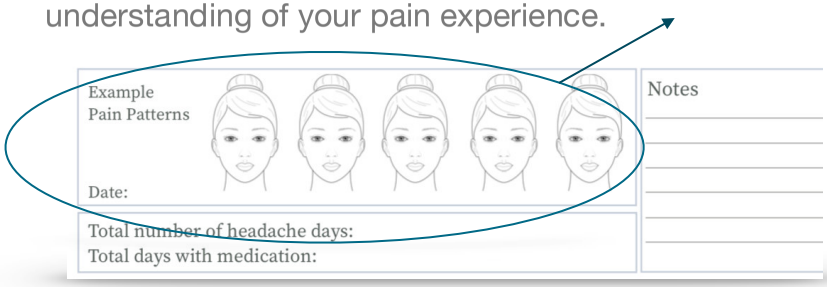


With the high prevalence of Medication overuse in headache sufferers it is also of great importance to keep track of the amount of medication that is taken.

Any medication that you take can be added to the box on the bottom right. By creating a code for each of those medications will mean that they are quick and easy to add to each day and take up much less space on the diary pages.



Headache and migraine can take many forms and vary from person to person. It may be useful to show where in your head and/or face that you experience the pain. If this changes from time to time it may be useful to record a few alongside the date, to give the doctor a greater understanding of your pain experience.

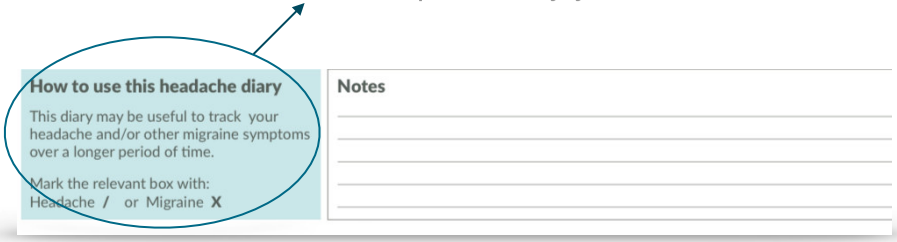


This monthly diary has been designed to fit any month. Simply add the dates to the top left of each box and the month and year in the spaces at the top of the page.

The Annual Migraine Diary

It can also be very useful to track your headache and migraine symptoms over a longer period of time. In addition to the monthly calendar the yearly calendar can be used to track symptoms and patterns over longer periods of time.

The calendar is simple to complete using the instructions in the bottom right corner although, it is also possible to add additional information if requested by your doctor.



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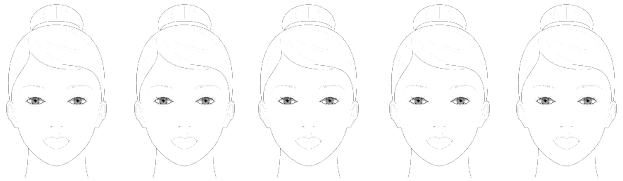
Month: Monthly Migraine and Headache Diary Year:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A I	A I	A I	A I	A I	A I	A I
A I	A I	A I	A I	A I	A I	A I
A I	A I	A I	A I	A I	A I	A I
A I	A I	A I	A I	A I	A I	A I
A I	A I	A I	A I	A I	A I	A I
A I	A I	A I	A I	A I	A I	A I

Example
Pain Patterns



Date:

Total number of headache days:
Total days with medication:

Notes

Medications: code:

- _____
- _____
- _____
- _____
- _____
- _____

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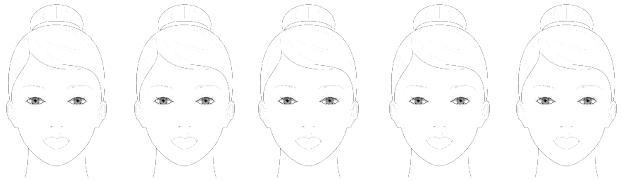
Month: Monthly Migraine and Headache Diary Year:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A I	A I	A I	A I	A I	A I	A I
A I	A I	A I	A I	A I	A I	A I
A I	A I	A I	A I	A I	A I	A I
A I	A I	A I	A I	A I	A I	A I
A I	A I	A I	A I	A I	A I	A I
A I	A I	A I	A I	A I	A I	A I

Example
Pain Patterns



Date:

Total number of headache days:
Total days with medication:

Notes

Medications: code:

- _____
- _____
- _____
- _____
- _____
- _____

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Annual Headache Diary

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Year:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Jan																															
Feb																															
Mar																															
Apr																															
May																															
Jun																															
Jul																															
Aug																															
Sep																															
Oct																															
Nov																															
Dec																															

How to use this headache diary

This diary may be useful to track your headache and/or other migraine symptoms over a longer period of time.

Mark the relevant box with:
Headache **/** or Migraine **X**

Notes

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