ELAWAR NEUROLOGY ASSOCIATES, INC.
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Headache/Head Pain/Facial Pain Questionnaire

Please fill out and bring to your appointment

Patient Name: _____

Where is the location of your headache?

All over head Top Back Right side Left side Neck

Describe the pain:

Aching Band-like Burning Dull Pounding Throbbing Sharp Other

How long have you been having headaches?____days ____weeks ____months ____years

How often does the headache happen? ____/day ____/week ____/month ____/year

How long does it last? Shortest _____ Longest _____

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

When do they happen? At work At home Sitting Standing Lying down Other _____

Do they start gradually or suddenly? _____

Are the headaches better, worse, or the same? _____

On a scale of 1-10, how severe is the pain? Least _____ Most _____

What makes it worse? (for women, please indicate if any relation to menstruation)

_____

Is it made worse by? Light Noise Odors Movement

What makes it better? _____

Please list all **OTC medications** you have tried or are currently taking for the headache, and how many pills a day?

_____

Please list all **prescribed medications** you have tried or are currently taking for the headache, and how many pills a day?

_____

Is the headache preceded by an aura? (ex: blurred vision, vision loss, zig-zag lines, flashing lights, confusion, speech difficulty)

_____

Has a headache limited your activity for a day or more in the last 3 months?

_____

Any other symptoms associated with the headache?

_____

Nausea _____ Vomiting_____ Other _____