Gina Greco -Tartaglia, M.D., FAAFP Zsuzsa Glasscock, FNP-C

HEADACHE QUESTIONNAIRE

Name _____ **Date** _____

Telephone (H): _____ Telephone _____

Date of Birth: _____ □ Female □ Male

Marital Status: □ Married □ Single □ Divorced □ Widowed

Race: □ Caucasian □ African American □ Hispanic □ Other _____

Occupation _____

1. How many regular headaches do you experience per month ?_____on average.

2. How many migraine headaches do you have per month ?_____on average.

3. How would you rate your general health in the last month? (Check one) □Excellent □Good □Fair □Poor

4. How many days in the last 3 months did you miss work or school because of your headaches ? ____ day

   How many ER visits did you have due to headache/migraine ? ___ day

5. How long do your migraine headaches usually last after you take your migraine medicine? (Check one)

   □ No more than 2 hours □ 3-4 hours □ 5-12 hours □ 12-24 hours □ Several days 1 week or longer

6. How long do your migraine headaches usually last if you do not take your migraine medicine? (Check one)

   □ No more than 2 hours □ 3-4 hours □ 5-12 hours □ 12-24 hours □ Several days 1 week or longer

7. How painful are your migraine headaches? (Circle one number) 1 2 3 4 5 6 7 8 9 10

8. Where are your migraine headaches usually located? (Check all that apply)

   □Behind right eye □ behind left eye □ behind both eyes □ Right temple □ left temple □ both temples

   □Above right eyebrow □ above left eyebrow □ above both eyebrows □ Back of head on right

   □ back of head on left □ back of head on both sides

9. How old were you when your migraine headaches started?_____

10. How would you describe your migraine headaches? (Check all that apply)

    □ Throbbing/pounding □ Ache/pressure □ Like a tight band □ Dull □ Other

11. Do your migraine headaches awaken you at night? □Never □ Occasionally □ Often

drt@drtfamilymedicine.com
225 Veterans Road, Suite 202, Yorktown Heights, NY – 10598
Phone : (914) 245-4186 Fax (914) 245-2290

12. Do any of the following occur before or during your migraine headaches? (Check all that apply)

□Nausea □ Vomiting □ Diarrhea □ Bothered by light/noise □ Blurred/double vision □ Sparkling or flashing lights □ Eyelid puffy □ Eyelid droops □ Loss of vision □ Feeling lightheaded □ Numbness / tingling □ Weakness of arm or leg □ Difficulty concentrating □Speech difficulty □Loss of consciousness □Runny nose Other_____

13. Do any of the following bring on your migraine headaches or make them worse? (Check all that apply)

□Stress (worry, anger) □Bright Sunshine □Weather change □Letdown" after stress □Loud noise

□Heavy lifting □Air travel □Fatigue □Certain smells or perfume □Missed meals □Sexual activity

□Coughing, straining, bending over □Certain foods (chocolate, cheese, beer, MSG)

□Other _____

14. Do any of the following make your migraine headaches better?

□Rest □Exercise □Quiet and darkness □Hot or cold compress □Massage □Warm shower

□Pressure over migraine headache area □Other _____

15. If you are female, do your migraine headaches change with the following? (Check all that apply)

□ Menstrual periods □Birth control pills □Pregnancy □Other hormonal drugs

16. Do any of your family members have migraine headaches? □No □Yes

If "yes", explain (who): _____

17. Have you ever had a head or a neck injury requiring medical treatment? □No □Yes

If "yes", describe: _____

18. Have you ever been diagnosed to have any health disorder (e.g. high blood pressure, asthma, heart disease, gastric ulcers)? □No □Yes

If "yes," please list: _____

19. Have you had your migraine headaches evaluated by a neurologist? □No □Yes

If "yes", when, where, and by whom?_____

What was the diagnosis? (Check all that apply)

□ Migraine □Tension-type □Cluster □Other, specify _____

20. Have your migraines been treated with Botox? □No □Yes

If "yes", when, where, and by whom?_____

drt@drtfamilymedicine.com
225 Veterans Road, Suite 202, Yorktown Heights, NY – 10598
Phone : (914) 245-4186 Fax (914) 245-2290

21. Did the Botox treatment work? □No □Yes

If "yes", for how long: _____

22. What site was the Botox injected? _____

23. List all past tests you had for your migraine headaches: _____

_____

24. Are you taking any *prescription* drugs to treat your migraine headaches? □No □Yes

If "yes", list the medications: _____

How many times in the last month have you used the prescribed medications?_____

25. Are you taking any *over-the-counter* drugs to treat your migraine headaches? □No □Yes

If "yes", list the medications: _____

How many times in the last month have you used the over-the-counter medications? _____

Comments: _____

_____

_____

_____

_____

drt@drtfamilymedicine.com
225 Veterans Road, Suite 202, Yorktown Heights, NY – 10598
Phone : (914) 245-4186 Fax (914) 245-2290

HEADACHE DIARY

Patient's name: _____ Date of birth: ____/____/____ Medical record #: _____

Date	Time	Duration	Intensity (1-10)	Triggers	Preceding symptoms	Treatment used	Response