HEADACHE HISTORY AND PROFILE

Name: _____ Date of Birth _____ Date _____

How often does the headache occur? ____ x / Day ____ x / Week ____ x / Month ____ x / Year ____ Constant

How old were you when any headaches started? _____

How long does the headache usually last? _____ Minutes _____ Hours _____ Days _____ Constant

Is the headache getting ☐ worse ☐ better ☐ fluctuating ☐ no change

Do your headaches interfere with or prevent normal activities - work, etc? ☐ No ☐ Yes

How long ago did the current headaches start? _____ Weeks _____ Months _____ Years

Describe the degree of pain (check one) ☐ 1 (slight) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (worse)

How would you describe the pain? ☐ Throbbing/ pulsating ☐ Pressing/ squeezing ☐ Stabbing ☐ Dull/ nagging ☐ Other

Does the headache awaken you from sleep? ☐ Yes ☐ No

On what part of the head do the headaches start?

☐ R Side ☐ Both sides ☐ Forehead ☐ Back ☐ Face ☐ Behind/ around eyes
☐ L Side ☐ Either side ☐ Temples ☐ On top ☐ Neck ☐ Other _____

After the headache starts: Does it usually ☐ Stay in one place ☐ Move around? Please explain:

Are any of the following associated with the headache? Please mark ☐ **B**efore ☐ **D**uring ☐ **A**fter the headache occurs.

B	D	A	
☐	☐	☐	Spots before eyes
☐	☐	☐	Blindness ☐ R ☐ L
☐	☐	☐	Blurring ☐ R ☐ L
☐	☐	☐	Double vision
☐	☐	☐	Can see only half of objects
☐	☐	☐	Eyelid droop ☐ R ☐ L
☐	☐	☐	Tearing ☐ R ☐ L
☐	☐	☐	Eye redness ☐ R ☐ L
☐	☐	☐	Eyes puffy ☐ R ☐ L
☐	☐	☐	Light sensitivity
☐	☐	☐	Noise sensitivity
☐	☐	☐	Odors sensitivity
☐	☐	☐	Nose blocked/ discharge ☐ R ☐ L
☐	☐	☐	Difficulty talking (finding words)
☐	☐	☐	Difficulty understanding
☐	☐	☐	Numbness around lips
☐	☐	☐	Slurred speech
☐	☐	☐	Fainting (feel like or have fainted)
☐	☐	☐	Dizzy (lightheaded/ unsteady/ spinning)

B	D	A	
☐	☐	☐	Nausea
☐	☐	☐	Vomiting
☐	☐	☐	Loss of appetite
☐	☐	☐	Hunger
☐	☐	☐	Cramps
☐	☐	☐	Diarrhea
			Hands and/or Feet:
☐	☐	☐	Cold
☐	☐	☐	Pale
☐	☐	☐	Sweaty
☐	☐	☐	Mottled
			Neck:
☐	☐	☐	Stiff
☐	☐	☐	Tender

B	D	A	
☐	☐	☐	Face ☐ R ☐ L
☐	☐	☐	Arms ☐ R ☐ L
☐	☐	☐	Arm & Leg ☐ R ☐ L
☐	☐	☐	Legs ☐ R ☐ L

B	D	A	
☐	☐	☐	Difficulty concentrating
☐	☐	☐	Depression
☐	☐	☐	Fatigue
☐	☐	☐	Anxiety
☐	☐	☐	Irritability
			Face - Scalp:
☐	☐	☐	Pale
☐	☐	☐	Redness
☐	☐	☐	Sweating
☐	☐	☐	Puffy
☐	☐	☐	Tender
☐	☐	☐	Decreased jaw opening
☐	☐	☐	Pain on chewing

W	N	B	
☐	☐	☐	
☐	☐	☐	
☐	☐	☐	
☐	☐	☐	

*Weakness (**W**)*
*Numbness (**N**)*
*Both (**B**)*

Indicate if any of the folllowing factors have brought on (triggered) your headache:

☐ Sleep: too much / too little
☐ Emotional stress ☐ during ☐ after

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- ☐ Depression / anxiety
- ☐ Physical activity
- ☐ Erect position
- ☐ Bending over
- ☐ Straining / coughing
- ☐ Sexual activity
- ☐ Change in weather
- ☐ Seasons

_____

- ☐ Missed meal
- ☐ Alcohol
- ☐ MSG

- ☐ Chocolate
- ☐ Citrus fruits
- ☐ Cheeses
- ☐ Other Foods

_____

- ☐ Menstrual periods
- ☐ Pregnancy
- ☐ Menopause
- ☐ Contraceptions
- ☐ Medications

Do any blood relatives have severe headaches? ☐ No ☐ Yes

If yes, who and diagnosis?

Which of he following makes the headache better?

- ☐ Rest
- ☐ Activity
- ☐ Darkness
- ☐ Quiet

Social History:

Cigarettes _____ / day _____ years

Are you or have you been ☐ Depressed ☐ Anxious

Previous professional treatment of headache? ☐ No ☐ Yes

If yes, who and when?

Previous x-ray or other investigations of headache? ☐ No ☐ Yes

If yes, describe:

Previous medications for headache? ☐ No ☐ Yes

If yes, name/ dosage:

Additional Notes: