HEADACHE HISTORY

Name ___________________________________________________ Date ________________________

It may seem strange to ask a person where his headache hurts, but the exact location in the head is important to help us make an accurate diagnosis. Please read through the entire history, then answer each question to the best of your ability and as accurately as possible. If uncertain, leave blank.

1. Location

Indicate the area of your head where your headaches seem to be concentrated. Please check those that apply:

___ A. Always on one side ( R ) ______ ( L ) ______
___ B. Alternates
___ C. Always on both sides
___ D. Over eyes
___ E. In eyes
___ F. Under eyes
___ G. Between eyes
___ H. Behind eyes
___ I. In temples
___ J. In teeth
___ K. Over cheeks
___ L. In top of head
___ M. In side of head
___ N. In back of head
___ O. In neck - back
___ P. In ears
___ Q. Other _____________________________________________________________

2. How long have you had these headaches? ___________________________________________

____________________________________________________________________________

A. They have become:
   ____ More Severe
   ____ Less Severe
   ____ Same Severity
   ____ More Frequent

B. They occur:
   ____ 1. Daily
   ____ 2. Weekly
   ____ 3. Monthly
   ____ 4. Periodic (several headaches followed by period of no headaches, only to recur several months later).
C. They begin:
   ____ 1. Slowly (over 20-30 minutes).
   ____ 2. Abruptly

D. They last:
   ____ 1. Seconds
   ____ 2. Minutes
   ____ 3. Hours
   ____ 4. Days

3. Headaches occur most often: (Please check appropriate blank).
   ____ A. Upon awakening in A.M.
   ____ B. Awakened in A.M. by headache
   ____ C. After getting up
   ____ D. Late morning
   ____ E. Later in day
   ____ F. Late afternoon
   ____ G. In evening
   ____ H. Awaken from sleep about 1-3 hours after going to bed
   ____ I. (In Females) In association with monthly periods
   ____ J. Every day for several days, then no headaches for periods of time
   ____ K. Just before meals
   ____ L. 1-2 hours after meals
   ____ M. Do you ever miss or skip meals and have headaches occur at time of normal meals?
   ____ N. Several hours after missing usual meal hour
   ____ O. Other _________________________________________________________________________

4. Headache pain best described as:
   ____ A. Steady
   ____ B. Pulsating
   ____ C. Throbbing
   ____ D. Shooting (if so, write from where to where) ____________________________________________
   ____ E. Other _________________________________________________________________________

5. Headaches are accompanied by: (Please check Yes or No)

   YES   NO
   ____   ____ A. Blockage or obstruction to breathing through nose.
   ____   ____ 1. If headache on only one side, nose obstructs same side
   ____   ____ 2. Both sides
   ____   ____ B. Runny nose
   ____   ____ 1. If headache on only one side, runny nose on same side.
   ____   ____ 2. Both sides
   ____   ____ C. Redness and watering of eye
   ____   ____ 1. If headache on only one side, the side of headache
   ____   ____ 2. Both sides
D. Changes in eyesight with headaches
   1. Flashes of light
   2. Decreased area of vision (tunnel vision)
   3. Double vision

E. Gastro-intestinal Symptoms
   1. Nausea
   2. Vomiting
   3. Abdominal cramps
   4. Diarrhea

F. Chest symptoms
   1. Chest pain
   2. Shortness of breath
   3. Difficulty breathing

6. List ALL medications you now take including non-prescription drugs (and birth control pills if taken).
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

7. Is there anything that you know of that brings on a headache? _______________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

8. Is there anything that you know of that aggravates a headache? _______________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

9. Is there anything that makes your headache better? __________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

10. Does reading or close work make headaches worse? _________________________________________

11. Does exertion make headaches worse? ____________________________________________________

12. Do you have any of the following diseases?
    YES   NO
   __   __  1. Arthritis
   __   __  2. Rheumatic disease
   __   __  3. High blood pressure (Hypertension)
   __   __  4. Diabetes
   __   __  5. Chronic kidney disease
   __   __  6. Ulcers of the stomach
   __   __  7. Asthma
   __   __  8. Hay fever
   __   __  9. Food allergies
   __   __ 10. Chronic constipation
13. Please list all illnesses you have had for the past 3 years. ______________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________  

14. Do you smoke? ___________________________________
What? ________________________________
How many? ________________________________

15. Do you use alcohol? ________________________________
How much per day? ________________________________
What form or forms?
Beer __________________________ Scotch ______________________
Wine __________________________ Gin _________________________
Bourbon ______________________ Vodka _______________________
Other __________________________________________________________________________________

16. Does headache ever occur within 30 minutes after use of alcohol? _________________________________
YES NO

17. Have you ever had a severe head injury?
When? ________________________________________________
What? ________________________________________________
How? ________________________________________________

18. Have you ever had a severe neck injury?
When? ________________________________________________
What? ________________________________________________
How? (Auto accident, sports, fall, etc.) ____________________________

19. Do you have:
YES NO

A. Feelings of tenseness of anxiety with no real cause
B. Financial problems
C. Marital problems
D. Problems with neighbors
E. Problems with employer
F. Problems with fellow employees
G. Problems with children
H. Problems with in-laws
I. Other ________________________________________________________________________________

_____________________________________________________________________________________
_____________________________________________________________________________________
# HEADACHE DISABILITY INDEX

NAME: ________________________ DATE: ________ AGE: ________ Scores Total: ______; E____; F____

(100) (52) (48)

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month  [2] more than 1 but less than 4 per month  [3] more than one per week

INSTRUCTIONS: (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off “YES”, “SOMETIMES”, or “NO” to each item. Answer each question as it pertains to your headache only.

<table>
<thead>
<tr>
<th>Item</th>
<th>YES</th>
<th>SOMETIMES</th>
<th>NO</th>
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<tbody>
<tr>
<td>E1. Because of my headaches I feel handicapped.</td>
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<td>F2. Because of my headaches I feel restricted in performing my routine daily activities.</td>
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<td>E3. No one understands the effect my headaches have on my life.</td>
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<td>F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.</td>
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<td>E5. My headaches make me angry.</td>
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<td>E6. Sometimes I feel that I am going to lose control because of my headaches.</td>
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<td>E7. Because of my headaches I am less likely to socialize.</td>
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<td>E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.</td>
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<td>E9. My headaches are so bad that I feel I am going to go insane.</td>
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<td>E10. My outlook on the world is affected by my headaches.</td>
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<td>E11. I am afraid to go outside when I feel that a headache is starting.</td>
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<td>E12. I feel desperate because of my headaches.</td>
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<td>F13. I am concerned that I am paying penalties at work or at home because of my headaches.</td>
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<td>E14. My headaches place stress on my relationships with family or friends.</td>
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<td>F15. I avoid being around people when I have a headache.</td>
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<td>F16. I believe my headaches are making it difficult for me to achieve my goals in life.</td>
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<td>F17. I am unable to think clearly because of my headaches.</td>
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<td>F18. I get tense (e.g. muscle tension) because of my headaches.</td>
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<td>F19. I do not enjoy social gatherings because of my headaches.</td>
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<td>E20. I feel irritable because of my headaches.</td>
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<td>F21. I avoid traveling because of my headaches.</td>
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<td>E22. My headaches make me feel confused.</td>
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<td>E23. My headaches make me feel frustrated.</td>
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<td>F24. I find it difficult to read because of my headaches.</td>
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<td>F25. I find it difficult to focus my attention away from my headaches and on other things.</td>
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