The Portland Clinic

# Department of Neurology
## *Headache Questionnaire*

**FIRST NAME:** _____ **LAST NAME:** _____

**DATE OF BIRTH:** _____ **PRIMARY CARE PROVIDER & CLINIC:** _____

**PREVIOUS NEUROLOGIST:** _____

At what age did you have your first headache: _____ What year did your current headaches begin: _____

When was your last headache: _____

Are you ever free of pain completely? ☐ Yes ☐ No

Do you have more than one type of headaches? ☐ Yes ☐ No

If yes, describe them separately: _____

_____

How many headaches do you have each month: _____ How long do they last: _____

**HOW WOULD YOU DESCRIBE THE PAIN OF YOUR MOST BOTHERSOME HEADACHES:**
(circle all that apply)

| | | |
|---|---|---|
| throbbing | aching | stabbing |
| pulsating | pressure-like | electric-like |
| dull | sharp | vise-like |

**ARE YOUR HEADACHES BROUGHT ON BY:**
(circle all that apply)

| | | |
|---|---|---|
| your periods/hormonal changes | alcohol | lack of sleep |
| exercise | bright light/glare | too much sleep |
| stress | odors | hunger |
| relaxation after stress | smoke | food additives |
| change in weather | noise | certain foods |



**Neurology Locations:**

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Do your headaches occur on any particular day of the week or time of day?_____

_____

Do you have any warning signs before the start of a headache? ☐ Yes ☐ No

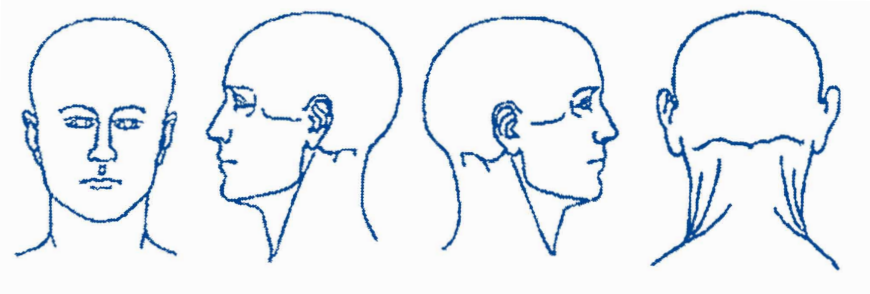
Describe: _____

## CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU HAVE WITH YOUR HEADACHES:

| | | |
|---|---|---|
| neck pain | noise sensitivity | difficulty speaking |
| nausea | numbness | tearing |
| vomiting | weakness | nasal congestion |
| light sensitivity | fever | eyelid drooping |
| dizziness | confusion | worsening of pain with movement |

other _____

## PLEASE INDICATE WITH X'S WHERE YOU EXPERIENCE PAIN:



Have you ever been treated for headaches? ☐ Yes ☐ No

What kind of headaches were you told you have: _____

Have you ever had any tests done to diagnose your headaches? ☐ Yes ☐ No

Describe: _____



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## WHICH OF THE FOLLOWING MEDICINES HAVE YOU TRIED FOR YOUR HEADACHES:

Circle all that apply | *Star those that helped, even for a short time

| | | | |
|---|---|---|---|
| Anaprox | Darvon / Darvocet | Indocin / Indomethacin | Propranolol |
| Aspirin | Dexamethasone / Decadron | Hydrocodone | Relpax |
| Anacin | Decongestants | Lamicital | Robaxin |
| Advil / Ibuprofen | DHE-45 | Lidocaine | Stadol |
| Aleve / Naproxen | Demerol | Lithium | Talwin |
| Amerge | Depakote | Lyrica | Topomax / Topiramate |
| Axert | Desyrel / Tradozone | Maxalt | Tylenol |
| Axotal | Dilantin / Phenytoin | Midrin | Ultram / Tramadol |
| Amitriptyline / Elavil | Effexor | Mirgralex | Ultracet |
| Atacand | Esgic | Migranal | Valium |
| Benicar | Ergostat | Motrin / Ibuprofen | Verapamil |
| Beta-blockers | Excedrin | Neurontin / Gabapentin | Wigraine |
| Botox | Fioricet / Butalbital | Panadol | Xanax |
| Bufferin | Fiorinal / Butalbital | Pamelor / Notriptyline | Zanaflex |
| Cafergot | Flexeril | Percocet / Oxycodone | Zomig |
| Calan | Frova | Percodan | Zonegran |
| Cymbalta | Imitrex / Sumatriptan | Percogesic | Other: |
| Codeine | Inderal / Propranolol | Phrenilin Forte | |

**Please list major side effects of medication:** _____

## HAVE YOU TRIED ANY OF THE FOLLOWING ALTERNATIVE TREATMENTS (circle):

Biofeedback

Acupuncture

Other _____

Chiropractic

Physical Therapy

Supplements: (Feverfew, B2, Magnesium, MigreLief, CoQ10, Butterbur, Petadolex)



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## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ9)

| Over the last two weeks, how often have you been bothered by any of the following problems? (use ✓ to indicate your answer) | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 2. Feeling down, depressed, or hopeless | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 4. Feeling tired or having little energy | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 5. Poor appetite or overeating | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 6. Feeling bad about yourself - or that you are a failure or have let yourself or you family down | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 9. Thoughts that you would be better off dead or hurting yourself in some way | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |

**For office coding:** 0 + _____ + _____ + _____

**= Total Score:** _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |



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## CURRENT SYMPTOMS - IN THE LAST 6 MONTHS: (please mark all that apply)

### 1. Head, Eyes, Ears, Nose, Throat, Lymph Nodes:

- ___ Headaches
- ___ Double vision
- ___ Hoarseness of voice
- ___ Tinnitus (buzzing or humming)
- ___ Photophobia (light bothers eyes)
- ___ Swollen and/or painful lymph nodes
- ___ Head trauma
- ___ Deafness
- ___ Neck swelling
- ___ Pain and/or drainage from ears
- ___ Nasal and/or sinus congestion
- ___ Visual loss or change
- ___ Nose bleeds
- ___ Neck stiffness
- ___ Sneezing
- ___ Sore throat
- ___ Glaucoma
- ___ Teeth grinding / clenching
- ___ Hearing problems
- ___ Vision problems
- ___ Dental problems
- ___ Sinus problems

### 2. Respiratory System:

- ___ Shortness of breath
- ___ Sputum/secretion production
- ___ Wheezing
- ___ Cough
- ___ Hemoptysis (coughing up blood)
- ___ Breathing difficulty

### 3. Cardiovascular System:

- ___ Chest pain, discomfort, heaviness, tightness
- ___ Shortness of breath with exertion
- ___ PND (waking up short of breath)
- ___ Orthopnea (sleeping on two or more pillows)
- ___ Leg swelling
- ___ High blood pressure
- ___ Palpitations
- ___ Chest pain
- ___ Heartburn

### 4. Gastrointestinal System:

- ___ Anorexia (poor appetite)
- ___ Nausea and/or vomiting
- ___ Constipation or diarrhea
- ___ Weight loss or gain
- ___ Hematochezia (red blood in bowel movements)
- ___ Melena (black bowel movements)
- ___ Jaundice
- ___ Abdominal pain
- ___ Dysphagia (difficulty swallowing)
- ___ Stomach pain
- ___ Weight change:
  loss _____ lbs , gain_____lbs

### 5. Genitourinary System:

- ___ Hematuria
- ___ Oliguria (infrequent urination)
- ___ Incontinence
- ___ Heavy menstrual flow
- ___ Polyuria (urination of large volumes of urine)
- ___ Nocturia (urination at night)
- ___ Frequency (frequent urination)
- ___ Pyuria (cloudy urine)
- ___ Urgency (sensation to urinate)
- ___ Sexual dysfunction
- ___ Symptoms of menopause
- ___ Irregular periods
- ___ PMS
- ___ Bladder problems
- ___ Excessive urination or thirst



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### 6. Nervous system:

- ___ Weakness/paralysis on one side of body
- ___ Urinary and/or fecal incontinence (wet or soiled underwear)
- ___ Memory loss, sleep disturbance, mood disorders (anxiety, depression)
- ___ Insomnia
- ___ Daytime sleepiness
- ___ Snoring
- ___ Sleep apnea
- ___ Seizures / shaking
- ___ Numbness
- ___ Loss of consciousness
- ___ Dizziness

### 7. Musculoskeletal System:

- ___ Joint pain / swelling / redness
- ___ Muscle aches and pains
- ___ Back pain
- ___ Neck pain
- ___ Leg / foot cramps
- ___ Leg restlessness
- ___ Weakness

### 8. Dermatological System:

- ___ Rash
- ___ Mole changes
- ___ Pigmentation (change in color)
- ___ Breast pain
- ___ Pruritus (itching)
- ___ Bleeding or bruising
- ___ Changes in nipples
- ___ Breast lumps / discharge
- ___ Allergic reaction
- ___ Change in skin / hair

## PAST MEDICAL HISTORY:

Have you had or do you have any of the following conditions?

| | Yes | No |
|---|---|---|
| Alcoholism | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Chest Pain | ☐ | ☐ |
| Colitis | ☐ | ☐ |
| Depression / Anxiety | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Drug Addiction | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Frequent Kidney Infections | ☐ | ☐ |
| Frequent Bladder Infections | ☐ | ☐ |
| Gallbladder disease | ☐ | ☐ |
| Gout | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| High Blood Pressure | ☐ | ☐ |
| Headache | ☐ | ☐ |
| Hepatitis | ☐ | ☐ |
| Heart Attack | ☐ | ☐ |
| Jaundice | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ |
| Other Heart Disease | ☐ | ☐ |
| Pain (Chronic) | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ |
| Stomach Ulcers | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ |
| Trouble Sleeping | ☐ | ☐ |
| Suicidal Thoughts | ☐ | ☐ |
| Other _____ | | |



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## FAMILY HISTORY Do you have a family member affected with:

| Condition | Yes | No | Type/affected relative | Condition | Yes | No | Type/affected relative |
|---|---|---|---|---|---|---|---|
| Brain Tumor | ☐ | ☐ | | Muscle Disease | ☐ | ☐ | |
| Seizures or epilepsy | ☐ | ☐ | | Hypertension | ☐ | ☐ | |
| Dementia | ☐ | ☐ | | Diabetes | ☐ | ☐ | |
| Parkinson's | ☐ | ☐ | | Migraines | ☐ | ☐ | |
| Multiple Sclerosis | ☐ | ☐ | | Neuropathy | ☐ | ☐ | |
| Thyroid Disease | ☐ | ☐ | | Other Neurological Disorder | ☐ | ☐ | |

Write other conditions: _____

_____

_____

## MEDICATION HISTORY

Please list all **MEDICATIONS** you take routinely, prescribed or over-the-counter, along with the dosages:

*(If you are a Portland Clinic patient and our list is up to date, leave blank.)*

| Medication: | Dose: | Frequency: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please list all allergies and sensitivities (e.g. medications, foods, latex, iodine, etc.)

_____



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## SURGERIES:

(List procedure and approximate year)

| Procedure | Year | Procedure | Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |



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