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
[11007 8/14]

The Portland Clinic - South
6640 SW Redwood Lane
Portland, OR 97224
(503) 620-7358

The Portland Clinic - Downtown
800 SW 13th Ave
Portland, OR 97205
(503) 221-0161

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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

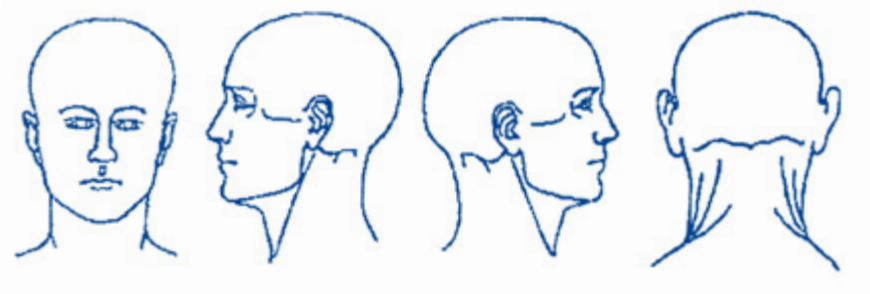
Describe: _____

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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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
- ___ Teethe grinding / clenching
- ___ Headaches
- ___ Hearing problems
- ___ Vision problems
- ___ Dental problems
- ___ Sinus problems

2. Respiratory System:

- ___ Shortness of breath
- ___ Sputum/secretion production
- ___ Wheezing
- ___ Cough
- ___ Hemoptysis
- ___ 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 swollowing)
- ___ 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 urnie)
- ___ 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 one side of body
- ___ Urinary and/or fecal incontinence (wet or soil 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)
- ___ Breast lumps
- ___ 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

PERSONAL HABITS:

Do you drink alcohol? Yes ____ No ____

If yes: Regularly ____ Socially ____

Hard liquor ☐ 1-3 oz per day ____ over 3 oz per day ____

Beer ☐ 1 bottle/can per day ____ 2 bottles/cans per day ____ 3 or more bottles/cans per day ____

Wine ☐ 1-2 glasses per day ____ 3-5 glasses per day ____ more than 5 glasses per day ____

Do you consume more than 5 drinks within a 24 hour period? Yes ____ No ____

How many days in the last 6 months did you consume more than 5 drinks in a 24 hour period? _____

Do you smoke? Yes ____ No ____

Have you smoked in the past? Yes ____ No ____

Do you or have you used recreational / illicit drugs? Yes ____ No ____

If yes, what have you used? _____

_____

When did you last use above substance? _____

Do you drink caffeinated drinks? Yes ____ No ____

If yes, list how many per day of the following: _____ Coffee; _____ Tea; _____ Soda; _____ Energy Drinks

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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 cafre of things at home, or get along with other people?

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

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