**Headache Questionnaire**

What age did your headaches begin?..............

What age did your facial pain begin?..............

1. When did your headache/head pain start? \_\_\_\_\_\_\_\_\_\_\_\_Month □ Year □ ago.

2. Family history of headaches Yes □ No □

3. Does your headache occur at the same time with current facial pain? Yes □ No□ If No

□ immediately after

□ immediately before

□ not related

4. Duration : For how long does each attack of headache usually lasts? (Untreated/without medication)

* 1-200 sec □….2-30 min □ ……. 15-180 min □ …….4-72h □ ……….continuous □

5. Site of headache

* Side : One side □ (right side □ / left side □ note ; if both side in different time please tick both right and left sides)

 Both side at the same time (bilateral) □

* Location : Around eyes□ Behind eyes□ Frontal□ Temples□ Back of head□ Neck□ Other……….
* Radiation: Does your headache arise from anywhere? ……………….Does your headache spread to anywhere? …………………

5. Nature of headache:

* Onset : related to an event? Yes□ No□ if yes Trauma□ Significant life event □ Stress □
* Characteristic/feeling : Throbbing □ Pulsating □ Stabbing □ Sharp □ Dull □

 Aching □ Pressure □ Squeezing □ Burning □ Tightening □ Other……………

* Severity: No pain□ Mild□ Moderate □ Severe □ Extreme □
* Time sequence: Constant □ Intermittent □ Steady but fluctuates □
* Frequency: Approximately how many days per month do you suffer from head pain? < 7 days □ 7-14 days □ > 14 days □

6. Any triggers for your headache? a) skipping meals □ b) alcohol □ c) weather changes□ d) menstrual period□ e) stress□

 f) too much or less sleep □ g) other…………………………

7. Do you have symptoms **precede or/and accompany** your headache? Yes □ (if yes, thick square below) No □

|  |  |  |
| --- | --- | --- |
| a) □ Seeing flashing lights, zig-zag lines or blind spots  | h) □ Nausea / vomiting | o) □ Eye redness and/or tearing |
| b) □ Partial or total loss of vision | i) □ Sensitivity to light | p) □ Change in pupil and/or Drooping eyelid |
| c) □ Doubled vision or blurred vision | j) □ Sensitivity to sound | q) □ Swelling of eyelid |
| d) □ Numbness/tingling sensation (like pins and needles) | k) □ Sensitivity to smell  | r) □ Nasal congestion or runny nose |
| e) □ One-sided weakness | l) □ Dizziness | s) □ Forehead and facial sweating |
| f) □ Loss of balance | m) □ Tinnitus | t) □ Sense of restlessness/agitation |
| g) □ Difficulty speaking/slurred speech□ Other ………………………………………………….. | n) □ Cutaneous allodynia (pain when hair brushing, head massage, wearing eye glasses, shaving, exposure to heat or cold) |

8.In the last 30 days, did the following activities change any headache (that is, make it better or worse) in your temple area on either side?

|  |  |
| --- | --- |
| a. Opening your mouth or moving your jaw forward or to the side Yes □ No □  | b. Chewing hard or tough food Yes □ No □  |
| c. Jaw habits like holding teeth together, clenching/grinding or chewing gum Yes □ No □  | d. Other jaw activities like talking, kissing, yawning Yes □ No □  |

9. Is your headache worse with a) standing up □ b) lying down □ c) bending over □ d) exercise□

 Is your headache made worse by movement? Yes □ No □

10. In the last 1 year how long have you been pain free? less than 3 months □ 3 months or more □

11. Medication used for headache Yes □ (if yes, please inform below) No□

Name medication…………………………… Frequency ………………… Duration………………… Is it effective? Yes □ No □

Name medication…………………………… Frequency ………………… Duration………………… Is it effective? Yes □ No □