Age your headaches began \_\_\_\_\_\_\_\_\_ (or how long ago did they start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Do you have more than one type of headache? YES NO

If yes, answer the following questions about your *most disabling headache type.*

Do you get any of the following symptoms hours to days before the headache starts?

Food cravings or hunger Unexplained mood change Uncontrollable yawning

Excessive thirst Excessive urination Drowsiness Euphoria Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What parts of your head and neck hurt? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What does it feel like (aching, throbbing, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do your headaches occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long do they last? On average \_\_\_\_\_\_\_Longest \_\_\_\_\_\_\_\_ Shortest \_\_\_\_\_\_\_\_\_

How severe is your pain? Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_

Do you have any warning before the pain starts (aura)? YES NO If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following **with your headaches** (Check all that apply)?

Nausea or inability to eat Worsening with activity (walking, climbing stairs)

Vomiting Numbness or tingling Ringing in ears

Sensitivity to light Weakness on one side of the body/face Imbalance

Sens

Sensitivity to noise Difficulty speaking Spinning dizziness

sens

Sensitivity to odors Confusion Double vision

SE

Diarrhea Tearing from the eye(s) Droopy eyelid

Stuffy nose Bloodshot eye(s) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Runny nose Restlessness

Do your headaches ever awaken you from sleep? YES NO If yes, at what time? \_\_\_\_\_\_\_\_\_\_\_\_

Do you have to/prefer to lie down with your headaches? YES NO

Do any of the following worsen your headaches? Coughing Sneezing Laughing Lifting

Straining or bearing down Sexual activity

Are your headaches better at any particular time of the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your headaches worse at any particular time of the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your headache severity affected by lying down, sitting, or standing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you identified anything that triggers your headaches? YES NO

*If yes*, list and describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have your headaches caused problems in any of the following areas of your life?

Job Housework School Home life Relationships Social life Legal

*Women*: Do any of the following affect your headaches? Ovulation Menstrual Period IUD

Birth Control Pill Pregnancy Menopause Hormone Replacement Therapy

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On average, how many days monthly are you *headache-free*? \_\_\_\_\_\_\_\_\_\_\_\_

Have you had a brain CT or MRI? YES NO

How much caffeine do you consume? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ In what form:

Coffee Tea Soda Chocolate Excedrin or medication

Do you use or consume food or beverages containing Nutrasweet/Equal/Aspartame? YES NO

How much sleep do you get every night on average? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours

Have you ever been told that you stop breathing or gasp during sleep? YES NO

Have you ever been diagnosed with sleep apnea? YES NO

Have you ever had a concussion? YES NO Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been physically, sexually, or emotionally abused? YES NO

Are you currently in an abusive relationship? YES NO

Do any family members have migraines or “sick headaches”? YES NO

If so, whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do any family members have cluster headaches? YES NO

If so, whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications have you tried for acute (symptomatic) treatment of headache (you took it when you got a headache)? Include medications for nausea and over- the- counter.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Dose (mg) | How long ago/when? | Was it effective? | Side effects |
|  |  |  |  |  |
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What medications have you tried for *prevention of headache* (take it daily to prevent headaches)?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Highest dose taken (mg) | How long did you use it? | Was it effective? | Side effects |
|  |  |  |  |  |
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**MIDAS DISABILITY ASSESSMENT**

*This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you.*

***INSTRUCTIONS:*** Please answer the following questions about all your headaches **over the last 3 months.** Write your answer – **one number**, **not a word or range –** in the box next to each question. Write a zero if you did not do the activity in the past **3 months**. If you don’t keep a headache calendar, provide your best estimate.

**DAYS** (one number per box)

|  |  |
| --- | --- |
| 1. On how many days in the last 3 months did you miss work or school because of your headaches? (If you did not attend work or school enter zero in the box.) |  |
| 2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? *(Do not include days you counted in question 1 where you missed work or school. If you do not attend work or school enter zero in the box.)* |  |
| 3. On how many days in the last 3 months did you not do household work because of your headaches? |  |
| 4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days counted in question 3, where you did not do household work.) |  |
| 5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches? |  |
| ***TOTAL (Questions 1-5)*** | |
| A. On how many days in the last 3 months did you have a headache? (If headache lasted more than one day, count each day.) |  |
| B. On a scale of 0-10, on average, how painful were these headaches? (Where 0=no pain at all, and 10=pain which is as bad as it can be.) |  |
| ***For office use only:*** 0-5 Little to none, 6-10 mild, 11-20 moderate, 21+ severe | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **GENERAL ANXIETY DISORDER SCALE (GAD-7)** | | | | |
| **Over the last 2 weeks, how often have you been bothered by the following problems?** | Not at all sure | Several days | Over half the days | Nearly every day |
|  | Score: 0 | Score: 1 | Score: 2 | Score: 3 |
| 1. Feeling nervous, anxious or on edge |  |  |  |  |
| 2. Not being able to stop or control worrying |  |  |  |  |
| 3. Worrying too much about different things |  |  |  |  |
| 4. Trouble relaxing |  |  |  |  |
| 5. Being so restless that it’s hard to sit still |  |  |  |  |
| 6. Becoming easily annoyed or irritable |  |  |  |  |
| 7. Feeling afraid as if something awful might happen |  |  |  |  |
| **Total Score** |  |  |  |  |
| **Sum of total scores** | | | |  |
| If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with people? | | | | Not difficult at all  Somewhat difficult  Very Difficult    Extremely Difficult |
| **For office use only:** 0-4 none, 5-9 mild, 10-14 moderate, 15+ severe | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ALLODYNIA QUESTIONNAIRE (ASC-12)** | | | | | |
| **How often do you experience increased pain or an unpleasant sensation on your skin during your most severe type of headache when you engage in each of the following?** | Does not apply to me | Never | Rarely | Less than half the time | Half of the time or more |
|  | Score: 0 | Score: 0 | Score: 0 | Score: 1 | Score: 2 |
| Combing your hair |  |  |  |  |  |
| Pulling your hair back (e.g., ponytail) |  |  |  |  |  |
| Shaving your face |  |  |  |  |  |
| Wearing eyeglasses |  |  |  |  |  |
| Wearing contact lenses |  |  |  |  |  |
| Wearing earrings |  |  |  |  |  |
| Wearing a necklace |  |  |  |  |  |
| Wearing tight clothing |  |  |  |  |  |
| Taking a shower (when the water hits your face) |  |  |  |  |  |
| Resting your face or head on a pillow |  |  |  |  |  |
| Exposure to heat (e.g., cooking, washing your face with hot water) |  |  |  |  |  |
| Exposure to cold (e.g., using an ice pack, washing your face with cold water) |  |  |  |  |  |
| **Total Score** |  |  |  |  |  |
| **Sum of total scores** | | | | | |
| **For office use only:** 0-2 none, 3-5 mild, 6-8 moderate, 9+ severe | | | | | |