

Return Visit Headache Questionnaire

Thank you for taking sufficient time to thoughtfully complete this questionnaire, this helps us improve your visit!

**Name:**

**DOB:**

**Today’s Date: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­**

**Have you been diagnosed with any new conditions, had any new surgeries, or been prescribed any new medications since your last clinic appointment? (Please list if applicable)**

**Are you currently pregnant?** YES NO **Are you planning pregnancy within the next year?** YES NO

1. Please list any current headache **preventive** medications **and current dosages** you are currently taking. These are medications that your doctor has asked you to take regularly to prevent headaches (medications, injections, Botox), even on the days you did not have a headache.
2. List any side effects experienced since your last clinic appointment that you feel are related to your headache preventive medications.

2b. If side effects are present, are these side effects (circle one):

Mild enough to tolerate given headache improvement Intolerable even if my headaches are better Tolerable, but headaches are not improved Intolerable and headaches are not better

1. Over the **past 4 weeks,** during how many days did you experience any head pain? (If you don’t know exactly, please provide your best estimate. Enter 00 if no headaches over the past 4 weeks

How many of these days involved moderate-severe pain?

1. How would you rate the AVERAGE severity and disability of your headaches currently?
	* 1. No headaches
		2. Mild, but no effect on functioning
		3. Moderate, normal activity difficult but possible on most days
		4. Severe, normal activity NOT possible on most days

Over the past 4 weeks are you experiencing any of the following?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Abdominal pain | NONE | mild | moderate | severe | MANAGED with current medications |
| Diarrhea | NONE | mild | moderate | severe | MANAGED with current medications |
| Constipation | NONE | mild | moderate | severe | MANAGED with current medications |
| Anxiety | NONE | mild | moderate | severe | MANAGED with current medications |
| Depression | NONE | mild | moderate | severe | MANAGED with current medications |
| Insomnia | NONE | mild | moderate | severe | MANAGED with current medications |
| Neck pain | NONE | mild | moderate | severe | MANAGED with current medications |
| Nausea | NONE | mild | moderate | severe | MANAGED with current medications |

Please list the acute (as needed) medications you have taken since your last clinic visit (include both prescribed and over the counter)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Acute Treatment | # of days per week taken | Effective at relieving pain? | How long does it take to work? | Does it keep your pain away? | Are there any intolerable side effects? |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

1. **Name Today’s Date**

\*\*Please indicate if you have had any trouble with these symptoms in the past 6 months\*\*

|  |  |  |
| --- | --- | --- |
| Pain with urinationMenses change or abnormal | YESYES | NONO |
| **10. Hematologic** |  |  |
| Adenopathy | YES | NO |
| Bruises or bleeds easily | YES | NO |
| **11. Musculoskeletal** |  |  |
| Back pain | YES | NO |
| Joint swelling/pain | YES | NO |
| Muscle pain/stiffness | YES | NO |
| **12. Neurological** |  |  |
| Blackouts | YES | NO |
| Loss of consciousness | YES | NO |
| Light-headedness | YES | NO |
| Loss of balance/falls | YES | NO |
| Numbness or shooting pains | YES | NO |
| in hands, arms, legs or feet |  |  |
| Seizures | YES | NO |
| Slurred speech | YES | NO |
| Weakness in arms or legs | YES | NO |
| **13. Psychiatric** |  |  |
| Change in sexual drive | YES | NO |
| Excessive daytime sleepiness | YES | NO |
| Loud snoring | YES | NO |
| Stop breathing, choking or | YES | NO |
| gasping while asleep |  |  |

Swelling in the legs/feet YES NO

|  |  |
| --- | --- |
| **2. Constitution** |  |
| Fatigue | YES | NO |
| Loss of appetite | YES | NO |
| Fever | YES | NO |
| Night sweats | YES | NO |
| Weight loss >10lbs | YES | NO |
| Weight gain >10lbs**3. Skin** | YES | NO |
| Rash | YES | NO |
| **4. Eyes** |  |  |
| Double vision | YES | NO |
| Eye pain | YES | NO |
| Sudden loss of vision | YES | NO |
| Vision changes**5. Ears/Nose/Throat** | YES | NO |
| Difficulty hearing | YES | NO |
| Sinus congestion | YES | NO |
| Ringing in the ears**6. Respiratory** | YES | NO |
| Coughing up mucus | YES | NO |
| Dry cough | YES | NO |
| Shortness of breath**7. Cardiovascular** | YES | NO |
| Chest pain or tightness | YES | NO |
| Rapid/fluttering heart | YES | NO |
| Pain in the calf muscles | YES | NO |
| when walkingShortness of breath | YES | NO |
| when lying flat |  |  |

**8. Gastrointestinal**

|  |  |  |
| --- | --- | --- |
| Abdominal (belly) pain | YES | NO |
| or cramping |  |  |
| Blood in stool | YES | NO |
| Constipation | YES | NO |
| Diarrhea | YES | NO |
| Difficulty swallowing | YES | NO |
| Nausea/Vomiting | YES | NO |
| **9. GU**Difficulty urinating |  | YES NO |

Little interest or pleasure in doing things over the past two weeks YES NO Feeling down, depressed or hopeless over the past two weeks YES NO Feeling nervous, anxious or on edge over the past two weeks YES NO

**14. Women**

Are you pregnant? YES NO Are you planning pregnancy within the year? YES NO

Are you breastfeeding? YES NO Are you post-menopausal? YES NO

If yes, at what age?