Neurology Specialists
an affiliate of MEDNAX

NEUROLOGY HEADACHE HISTORY QUESTIONAIRE

TODAY'S DATE_____

NAME OF PATIENT_____

AGE_____ **BIRTH DATE**_____

HOW LONG HAS HE/SHE HAD THE HEADACHES _____

DO HEADACHES LAST FOR: MINUTES / HOURS / DAYS / WEEKS

ARE THE HEADACHES: EVERYDAY / 1-2 A WEEK / 1-2 A MONTH / 1-2 A YEAR / FIRST TIME

WHERE IN THE HEAD DOES IT HURT_____

DO THEY WAKE HIM/HER_____

HEADACHE SEVERITY: Least _____ Worst

1 2 3 4 5 6 7 8 9 10

ARE THE HEADACHES: POUNDING / PRESSURE LIKE / SQUEEZING / SHARP / DULL ACHE

DO LIGHT AND SOUND BOTHER WHEN HAVING HEADACHES_____

DOES SLEEPING HELP_____

ARE HEADACHES WORSE: WAKING UP / DAYTIME / AFTERNOONS / EVENINGS / NIGHT

LIST ALL MEDICATIONS USED_____

_____

WHAT MEDICINE WORK BEST_____

WHAT RELIEVES THE HEADACHES_____

WHAT BRINGS ON THE HEADACHES_____

ANY NAUSEA OR VOMITTING_____

ANY ASSOCIATED FEATURES: BLURRED VISION / DOUBLE VISION / DIZZINESS / WEAKNESS / PARALYSIS / _____

ANY OTHER FAMILY MEMBERS WITH HEADACHES_____

ARE THE HEADACHES SIMILAR (IF NO EXPLAIN)_____

_____

ANY TESTING DONE SO FAR_____

RESULTS OF THOSE TESTS_____

ANTHING ELSE YOU WANT TO EXPLAIN ABOUTH THESE HEADACHES_____

_____

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