Name: _____ DOB: _____ Date of Service: _____

1. Did you ever suffer from motion sickness as a child _____
2. Do you ever feel lightheaded or off-balance with a headache? _____
3. Do you ever experience difficulty thinking or speaking clearly with a headache? _____
4. Do any family members have similar headaches? _____ Who? _____
5. Have you noticed any paralysis, muscle weakness, numbness, swallowing problems or speech changes? _____

If yes-during your headaches only? _____ or between headaches or all of the time? _____

6. Do you ever have diarrhea after a headache? _____
7. Do you have watering of the eye or runny nose on the affected side of the headache? _____
8. Does your eye become bloodshot during a headache? _____
9. Do you get headaches which wake you during the night? _____
10. Do you get headaches during or following exercise? _____
11. Does coughing or sneezing ever cause a headache to start? _____
12. Do you experience headaches which start during sexual activity? _____
13. Does talking or chewing trigger or worsen your headaches? _____
14. Do you hear a noise inside your head like water flowing? _____
15. Does touching your face trigger or worsen headaches? _____
16. Does eating cold food or drink trigger or worsen headaches? _____
17. Does skipping a meal trigger headaches? _____
18. Do you tend to pace the floors with a headache? _____
19. Are your headaches so excruciating that you have considered suicide? _____
20. Can you have 6-12 month periods when you experience NO headaches? _____
21. Is your headache less bothersome if you keep active at work or play? _____
22. Do your neck or shoulder muscles feel tight and painful during the headache? _____
23. Men, do you take a medication for erectile dysfunction? _____
24. Do you work outside the home? _____ If yes where and what do you do there? _____

List the medications (including over the counter medications) you have tried for your headaches. They are graded on a scale: 1 = no relief 2= minimal relief 3=moderate relief 4= complete relief. How many days per week do you take any of the following medications

- Tylenol _____
- Advil_____
- IBU_____
- Excedrin or Excedrin migraine_____
- Aspirin_____
- Prescription abortive headache medications _____ if yes list medication tried _____