LIVE WELL NEUROLOGY AND SLEEP
Nadia F. Zaki MD

# HEADACHE QUESTIONNAIRE

THIS QUESTION AND ANSWER FORM IS INTENDED TO HELP THE DOCTOR BETTER UNDERSTAND YOUR HEADACHES AND COMPLAINTS.
PLEASE ANSWER ALL THE QUESTIONS TO THE BEST OF YOUR ABILITY.

Patient Name _____ Date _____

1. Please describe your headache

_____

_____

2. At what age did they start _____

3. How frequent do you have headaches?_____
(how many times daily, weekly or monthly?)

4. Location of headache _____

5. What time of day does headache usually start? _____

6. How long does headache last? _____

7. Do you get any warning prior to headache? _____

8. Do you see any spots, vision floaters, or bright lights during or prior to your headaches?

_____

9. Any dizziness/confusion/numbness/tingling or weakness in arms or legs during Headache _____

_____

10. How do you feel after the headache? _____

11. Does light or noise bother you during headache _____

12. Any food or other triggers you know of that brings on the headache _____

_____

13. On a scale OF 1-10 severe are your headaches? _____

14. Any other family members having similar or different headaches?
_____

15. Any relationship of headache due to stress, anxiety or depression?
_____

16. Any known trauma to head? _____

17. Any passing or blacking out episodes during headache or otherwise? _____
_____

18. Any known snoring, sleep apnea (stop breathing), or difficult habits at night? _____
_____

19. Any complaints of Extreme Daytime Sleepiness (EDS), fatigue, or tiredness?
_____

20. Any known depression, or anxiety? _____

21. Ever felt suicidal or homicidal? _____

22. What kind of neuro testing have you had and when? _____
(like MRI, CT of head EEG, ect.) _____

23. What kind of medications have you used for your headaches? (Name and strength)

_____
_____

24. Have you ever been treated by a psychiatrist or therapist or neurologist in the past,
If so, when and how long ago? _____
_____