Headache Diagnosis Questionnaire

Date:_____

Name:_____**DOB**:_____

1) How long have you been suffering with headaches?
2) How old were you when the headaches began?
3) Do you know when a headache is coming- (Aura)?
4) How often do you get a headache?
5) Please describe any aggravating or precipitating factors:
6) How long do the headaches last?
7) Where is the pain located?
8) Describe the pain:
9) Rate your pain on a scale of 1-5: 1 2 3 4 5
10) Are there any other symptoms?
11) Are there any visual symptoms?
12) Do you have a family history of headaches?
13) How do the headaches impact your life?
14) Are the headaches disabling? Are you able to work? Do you have to lie down?
15) Previous diagnosis studies:
16) Previous medication(s) you have tried:
17) Current treatment if any:
18) Any additional information:

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