FIRST Choice NEUROLOGY

Headaches Questionnaire

Do you have headaches often? If so answer the questions below to determine the severity of your headaches.

Please check off **“Frequency”** if you answer yes to either

1. In the past 3 months have you had 45 days of headaches?
2. In the past month have you had 15 days of headaches?

Please check off **“Medication Use”** if you answer yes to either

1. Have you used **over-the-counter** medication 10 days or more, for your headaches?
2. Have you used **prescription** medication 10 days or more, for your headaches?

Please check off **“Symptoms”** if you answer yes to any of the below

1. Are you sensitive to light more than half of your day?
2. Are you sensitive to sound more than half of your day?
3. Do you feel the light and sound has been affecting you more than usual?
4. When you get headache, do you often feel nauseated or sick to your stomach?

Please check off **“Activities”** if you answer yes to either.

1. Have you missed 10 days or more from work or school in the past month?
2. Have you missed 10 days of your social, family, or leisure activities because of your headaches?

Please check off **“Making Plans”** if you answer yes to either.

1. Do your headaches interfere with you making plans?
2. Are you afraid to make plans due to frequent headaches?

Check Box
Please check off the follow if they pertain to you.

☐ **Frequency** ☐ **Activities** ☐ **Making Plans**

☐ **Medication Use** ☐ **Symptoms**

If you checked two or more boxes ask your doctor if you have chronic migraines and what treatments are available.