

## Associated Neurological Specialties

Dr. Robert Cain

Dr. Jill Heytens

Dr. George Petroff

Patient Name:

Today's Date:

<b>ASSOCIATED NEUROLOGICAL SPECIALTIES HEADACHE QUESTIONNAIRE</b>
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1. How many severe headaches per month?
2. How long does a headache last?
3. Are your headaches better or worse?
4. What is the total number of headache days, mild and severe, per month?
5. Have your headaches changed in location or intensity or are there any new associated symptoms?
6. List the medications you take for your headaches:

PREVENTION	ACUTE TREATMENT

7. Have you developed any new illnesses since your last visit not previously described?
8. List any medications you have tried in the past and discontinued because of side effects or lack of efficacy.

NAME OF MEDICATION	REASON FOR DISCONTINUING

9. Have you identified any recurrent cause for your headache (i.e. stress, alcohol, food, menstrual cycles)?

10. Your headaches are characterized by (check all that apply):

<input type="checkbox"/> Pounding	<input type="checkbox"/> Vice-like	<input type="checkbox"/> Unbearable	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Photophobia	<input type="checkbox"/> Phonophobia
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11. Have you developed (check all that apply):

<input type="checkbox"/> Depression	<input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Elevated Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Constipation	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Heart Disease	

12. Estimate the total number of over-the-counter medications and total # of pills you take per month – all types.

13. Method of contraception.