Headache Patient Questionnaire

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| --- | --- | --- | --- |
| If your scan is being done for a NEW or DIFFERENT headache, which you having RIGHT NOW, please answer the following: | | | |
| Yes | No | Don’t know |  |
|  |  |  | This is the worst headache I’ve ever had in my life. |
|  |  |  | This is the first headache I’ve ever had in my life. |
|  |  |  | I have a fever or chills. |
|  |  |  | My neck feels stiff. |
|  |  |  | I have blurred vision or double vision. |
|  |  |  | I have ringing in my ears or dizziness/vertigo. |
|  |  |  | I have jaw pain with my headaches. |
|  |  |  | I have numbness or weakness in my arms or legs. |
|  |  |  | I have difficulty speaking. |
|  |  |  | I have sinus congestion and/or drainage. |
|  |  |  | I am (or was) a smoker. |
|  |  |  | I have (or have had) strokes. |
|  |  |  | I have (or have had) cancer. |
|  | | | |
| If your scan is being done for REPEATED headaches, please answer the following: | | | |
| My headaches usually last about (how long): | | | |
| My headaches are usually (circle one): mild moderate severe | | | |
| Yes | No | Don’t know |  |
|  |  |  | Light makes my headaches worse. |
|  |  |  | Sound makes my headaches worse. |
|  |  |  | My headaches get worse with normal physical activity. |
|  |  |  | My headaches have a throbbing (pulsating) quality. |
|  |  |  | I have nausea with my headaches. |
|  |  |  | I have vomiting with my headaches. |
|  |  |  | My headaches involve only one side of my head. |
|  |  |  | My headaches involve both sides of my head. |
|  |  |  | One of my eyes produces tears with the headaches. |
|  |  |  | One side of my head sweats with my headaches. |

If you had a recent head injury, please describe what happened here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long as your headache lasted:\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you say your headache is mild, moderate, or severe: \_\_\_\_\_\_\_\_\_\_\_\_\_