***PEDIATRIC CARE of KENTUCKY***

**HEADACHE QUESTIONNAIRE**

**NAME:** _____ **DATE:** _____

***Please answer the following questions prior to your appointment and bring this questionnaire with you!***

1. HOW LONG HAVE HEADACHES BEEN OCCURRING?

_____

_____

2. WHERE IS THE PAIN? DOES IT MOVE AROUND OR STAY IN ONE PLACE?

_____

3. HOW OFTEN DOES PAIN OCCUR? (Every day, 5 times per week, once per week, once per month, only on weekends, etc.)

_____

_____

4. WHAT DOES PAIN FEEL LIKE? (Stabbing, burning, pounding, etc.)?

_____

_____

5. ON A SCALE OF 1 to 10, HOW SEVERE IS PAIN? _____

_____

6. WHEN DOES PAIN OCCUR? IS THERE A CERTAIN TIME OF DAY WHEN THINGS ARE WORSE?

_____

_____

7. HOW LONG DOES IT LAST? (A few seconds, 5 minutes, 3 hours, etc.)

_____

_____

8. DOES THE PAIN CAUSE WAKING FROM SLEEP? _____

_____

9. IS THERE ANYTHING THAT CAUSES THE PAIN TO BE WORSE? (EX: certain foods, decreased sleep, stress, physical activity, menstrual period). Please describe:

_____

_____

10. WHAT HAS BEEN TRIED FOR THE PAIN? _____
DID IT WORK? ____ YES _____NO. WHAT DOSAGE OF MEDICINE WAS USED (if any)? _____ HOW LONG WAS IT USED? _____

11. DO HEADACHES CAUSE VOMITING OR NEAR VOMITING? DESCRIBE: _____

12. IF MENSTRUATING, WHEN WAS LAST PERIOD? _____ ANY CHANGE IN PERIOD? _____ ANY DISCHARGE? _____
WHAT ARE PERIOD USUALLY LIKE? (How often, how many days, do you cramp, how many pads are used on heaviest days? _____

13. DOES THE PAIN HAPPEN AS MUCH ON SCHOOL DAYS AS IT DOES ON WEEKENDS & HOLIDAYS? _____YES _____NO.

14. HAVE THERE BEEN IMPORTANT CHANGES OR STRESS (Trouble in school, parents separating, worries, a move, a lead in a play, etc.?) Please Describe:

15. IS THERE A FAMILY HISTORY OF HEADACHES? DESCRIBE: _____

16. IS THERE WEAKNESS, NUMBNESS, VISION OR OTHER PROBLEMS WHEN A HEADACHE OCCURS? (DESCRIBE): _____

17. DO HEADACHES CAUSE SLEEP OR MAKE IT HARD TO SLEEP?

18. ARE THERE ANY WARNING SIGNALS BEFORE A HEADACHE OCCURS? (EX: flashes of light?). _____

19. ARE SINUSES OR ALLERGIES A PROBLEM? Please Describe: _____

20. ARE THERE PROBLEMS WITH BLURRED VISION? _____YES _____NO
a.) How long has it been since the last eye exam? _____
b) Do you wear glasses or contacts? _____

21. WHICH MEALS ARE EATEN DAILY? IS DIET HEALTHY? Explain. _____

22. DOES COUGHING CHANGE THE HEADACHE? _____

23. ARE HEADACHES AFFECTED BY LIGHT OR NOISE? Describe How _____

Thank you for answering the above questions. Please bring this questionnaire with you on your visit to see the doctor!