**HEADACHE HISTORY**

1. **How many headaches have you had in the last month?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **How long does a typical headache last?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Where is your headache located**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Please describe your headache pain:** Sharp Dull Throbbing Tight/Squeezing

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **How does your headache affect your daily activities?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Check any of the following that occur when you have a headache:**

\_\_ Flashing lights or wavy lines \_\_Watery eyes or runny nose

\_\_Nausea or Vomiting \_\_Sweating

\_\_Sensitivity to light or sound \_\_Eyelid swelling

\_\_Numbness or tingling \_\_Nasal congestion

1. **Does anyone else in your family have similar symptoms?** Yes No if yes, who\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Do any of the following make your headache better?**

\_\_Sleep \_\_Medication (if yes, what type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Menstrual cycle \_\_Stress/Worry \_\_Exercise \_\_Bending forward

1. **Do any of the following make your headache worse?**

\_\_Sleep \_\_Medication (if yes, what type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Menstrual cycle \_\_Stress/Worry \_\_Exercise \_\_Bending forward

1. **How many times per day do you use headache medications?**

\_\_\_I do not use it daily

\_\_\_Once

\_\_\_1-4 times

\_\_\_More than 4 times daily