HEADACHE CLINIC
THE UNIVERSITY OF BRITISH COLUMBIA

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Name:_____
Age:_____
Handedness: right/ left/ ambidextrous
Occupation:_____
If on disability, disability start date:_____
Marital status:
Single_____commonlaw_____separated_____divorced___widowed___ Married
Children's ages_____
Cause of disability ie. headaches, other:_____
Name of Third Party Medical Insurer and details_____

Existing and Past Medical Conditions (please circle and list)
Heart disease (chest pain, heart attack) Kidney stones
High Blood pressure Asthma
Depression Anxiety

Other_____
_____

Surgeries, please list dates:

CurrentMedications:_____
_____
Medication Allergies:_____

How would you rate your mood in general?
Excellent Good Neutral Sad Depressed

How is your sleep?
Good Difficulty falling asleep Difficulty maintaining sleep
Do you wake up with headache in the morning?

Meals
Do you eat breakfast ? Yes No
Do you eat regular meals over the day? Yes / No Do you skip meals Yes / No

On average, how much caffeine do you consume daily? (# of drinks/day)
Coffee _____
Tea _____
Soft drinks_____
How much alcohol do you drink on average? _____drinks/day _____per week
_____per month

How much do you smoke?_____When did you quit?_____
Do you do any regular exercise?
No Yes Describe _____

Is there a family history of headaches? Yes / No
Which family member?_____

Is there a family history of stroke/ heart disease or neurological disease?_____

Headache Characteristics

Onset
Did you suffer from headaches when you were younger?
As a child
As a teenager
As a young adult (20's-40's)
Comment_____

When did your current headache problems begin?
Headaches became a problem? _____months _____Years ago

Precipitating Event: Was there a precipitating event or trigger for your current headache problem?
None known Specific Stress Injury Motor vehicle accident illness
Menarche (First period) Birth Control Pilll Pregnancy Hormone replacement
Other _____

What are the triggers for your headaches?
alcohol food intercourse exercise coughing
Other_____

How many headache free days do you have per month?_____

Frequency of headaches – on average, how often do you have a headache?
They occur _____ times each _____Day _____Week _____Month
Are they increasing in frequency? Yes / No

Onset of each headache
Headaches typically begin gradually / suddenly / varies
They usually begin in the morning / afternoon / evening /night
How long before they reach maximal intensity ? _____ minutes _____hours

Duration of headaches:
Headaches usually last (with medication) ____ minutes _____hours _____ days
Headaches usually last(without medication) ____minutes _____hours _____days

Intensity of the headaches- How bad are your headaches? On a scale of 0-10 with 0 being no pain, and 10 being the worst pain you could imagine, How do you rate your headaches on your best day_____/ 10 your worst day_____/10

What best describes the quality of your headache? Circle all those that apply. throbbing/stabbing/pressure/aching
Where do you experience the pain? Face/ head/ neck/ other
Details_____
When you have your headache do you have nausea/vomiting

When you have your headache would you prefer to avoid bright lights/loud noises

Would you prefer to lie down when you get your headaches? Yes/ No

Do you experience other symptoms such as : vision problems/dizziness/speech

troubles/numbness or tingling/ loss of strength/ringing ears/poor balance /or

coordination difficulties /swallowing difficulties (circle all those that apply)

What makes your headaches better (rest, medications, exercise etc.?)_____

How long does your average headache last?_____

Review of Symptoms

Please circle if you have been experiencing any of the following:

Numbness or tingling in your legs	Fever	Weight loss
Change in bowel or bladder function	Night Pain	Chills
Loss of balance or Coordination	Dizziness	Loss of Hearing
Loss or Change in Vision	Changes in Speech or Swallowing	

Tests: type ie. x ray/ CT / MRI and facility test performed and date ie. VGH, Burnaby
Hospital_____
_____
_____

Medication tried (Circle)	Duration	Benefit	Side effect?
Metoprolol/propranolol Atenolol/nadolol/timolol			
Verapamil/flunarizine			
Amitriptyline/nortriptyline			
Topiramate			
Valproic Acid			
Botox			
Gabapentin/ lyrica			

Venlafaxine			
Other			
	Frequency	Benefit	Side effect?
Tylenol			
Cambia			
Ibuprofen			
Naproxen			
Imitrex/Relpax/Zomig/ Axert/Maxalt/ Amerge/			
Tramadol			
T#3/ Fiorinal			
morphine			
Other			

What are your hopes for today's visit?_____
_____
_____
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