Stony Brook Medicine

Neurology Associates of Stony Brook, U.F.P.C.
179 Belle Mead Rd., Suite 3,
E. Setauket, NY 11733

Headache Questionnaire

At what age did you have your first headache: _____ What year did your current headaches begin: _____

When was your last headache: _____

Are you ever free of pain completely? ❑ Yes ❑ No

Do you have more than one type of headaches? ❑ Yes ❑ No

If yes, describe them separately: _____

_____

How many headaches (any type) do you have each month: _____, how long do they last: _____

How would you describe the pain of your most serious headaches (circle one or several):

throbbing pulsating dull aching pressure-like

sharp stabbing electric-like vise-like

Does the pain like: ❑ going from outside - in (compressing, stabbing) ❑ from inside - out (exploding, pushing out)

When you have a headache (and possibly after), does your scalp and face become sensitive to touch and do you avoid putting on glasses, jewelry or combing your hair? ❑ Yes ❑ No

Are your headaches brought on by:

your periods / hormonal changes exercise stress relaxation after stress change in weather alcohol bright light / glare odors smoke noise lack of sleep too much sleep hunger food additives certain foods

Do your headaches occur on any particular day of the week or time of day? _____

_____

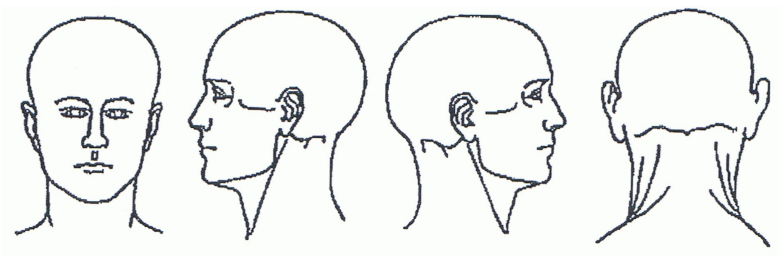
Do you have any warning signs before the start of a headache? ❑ Yes ❑ No

Describe: _____

Circle any of the following symptoms you have with your headaches:

neck pain nausea vomiting light sensitivity dizziness noise sensitivity numbness weakness fever confusion difficulty speaking tearing nasal congestion eyelid drooping worsening of pain with movement other: _____

Please indicate with X's where you experience pain:



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Have you ever been treated for headaches? ❑ Yes ❑ No

What kind of headaches were you told you have: _____

Have you had any tests done to diagnose your headaches? ❑ Yes ❑ No

Describe: _____

Which of the following medicines have you tried for your headaches (of any kind) (circle):

Anaprox	Codeine	Imitrex / Sumatriptan	Percogesic
Aspirin	Darvon / Darvocet	Inderal / Propranolol	Phrenilin Forte
Anacin	Dexamethasone / Decadron	Indocin / Indomethacin	Relpax
Advil / Ibuprofin	Decongestants	Lamictal	Robaxin
Aleve / Naproxen	DHE-45	Lidocaine	Stadol
Amerge	Demerol	Lithium	Talwin
Axert	Depakote	Lyrica	Topamax / Topiramate
Axotal	Desyrel / Tradozone	Maxalt	Tylenol
Amitriptyline / Elavil	Dilantin / Phenytoin	Migralex	Ultram / Tramadol
Atacand	Effexor	Migranal	Ultracet
Benicar	Esgic	Motrin / Ibuprofin	Valium
Beta-blockers	Ergostat	Neurontin / Gabapentin	Vivactyl / Protriptyline
Botox	Excedrin	Naprosyn / Anaprox	Wigraine
Bufferin	Fioricet / Butalbital	Panadol	Xanax
Cafergot	Fiorinal / Butibital	Pamelor / Notriptyline	Zanaflex
Calan / Verapamil	Flexeril	Percocet / Oxycodone	Zomig
Cymbalta	Frova	Percodan	Zonegran
			Other:

*Star those which helped, even for a while.

Have you tried any of the following alternative treatments (circle):

Biofeedback Acupuncture Chiropractic Physical Therapy Other: _____

Supplements: (Feverfew, B2, Magnesium, MigreLief, CoQ10, Butterbur, Petadolex)

List all the headache medications and the amounts you are now taking (over the counter or prescribed):

-	-	-
-	-	-
-	-	-
-	-	-

List all other medications you are taking for any reason:

-	-	-
-	-	-
-	-	-
-	-	-

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Headache Questionnaire

MIDAS Questionnaire | Migraine Disability Assessment

Patient Name: _____ **Date:** _____

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you.

INSTRUCTIONS: Please answer the following questions about all of your headaches over the last 3 months. Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months.

1. On how many days in the last 3 months did you miss work or school because of your headaches? (if you do not attend work or school enter zero in the space to the right). ☐

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school. If you do not attend work or school, enter zero in the space to the right). ☐

3. On how many days in the last 3 months did you not do household work because of your headaches? ☐

4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school. If you do not attend work or school, enter zero in the space to the right). ☐

5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches? ☐

A. On how many days in the last 3 months did you have a headache? (If headache lasted more than 1 day, count each day.) ☐

B. On a scale of 0-10, on average, how painful were these headaches? (0 = no pain at all, and 10 = pain which is as bad as it can be.) ☐

Add the total number of days from questions 1 to 5 (ignore A and B). ☐

During the past month:

1) Have you been bothered a lot in the last month by feeling sad, down, or depressed? ❑ Yes ❑ No

2) Have you been bothered a lot in the last month by a loss of interest or pleasure in your daily activities? ❑ Yes ❑ No

For Men: When was the last time you had more then five drinks in one day?

❑ Never ❑ In the past three months ❑ Over three months ago

For Women: When was the last time you had more then four drinks in one day?

❑ Never ❑ In the past three months ❑ Over three months ago

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Have you had any of the following problems in the past 6 months:

- ❑ Change in marital status
- ❑ Change in job / school
- ❑ New illness diagnosed
- ❑ Emotional trauma
- ❑ Change in smoking / drinking / diet
- ❑ Hospitalizations / surgery
- ❑ Fatigue
- ❑ Bruising
- ❑ Weight change; loss _____ lbs, gain _____ lbs
- ❑ Allergic reaction
- ❑ Skin rash
- ❑ Fever / chills
- ❑ High blood pressure
- ❑ Palpitations
- ❑ Breathing difficulty
- ❑ Chest pain
- ❑ Swelling
- ❑ Chronic cough
- ❑ Wheezing
- ❑ Bleeding / bruising
- ❑ Diarrhea
- ❑ Constipation
- ❑ Heartburn
- ❑ Stomack pain
- ❑ Nausea / vomiting
- ❑ Joint pain / swelling / redness
- ❑ Muscle aches
- ❑ Sexual dysfunction
- ❑ Breast lumps / discharge
- ❑ Symptoms of menopause
- ❑ Irregular periods
- ❑ PMS
- ❑ Bladder problems
- ❑ Cold extremities
- ❑ Leg / foot cramps
- ❑ Depression
- ❑ Anxiety / panic attacks
- ❑ Change in skin / hair
- ❑ Excessive urination or thirst
- ❑ Insomnia
- ❑ Leg restlessness
- ❑ Daytime sleepiness
- ❑ Snoring
- ❑ Sleep apnea
- ❑ Teeth grinding / clenching
- ❑ Seizures / shaking
- ❑ Headaches
- ❑ Back pain
- ❑ Neck pain
- ❑ Decline in memory
- ❑ Weakness
- ❑ Numbness
- ❑ Hearing problems
- ❑ Vision problems
- ❑ Loss of consciousness
- ❑ Dizziness
- ❑ Dental problems
- ❑ Sinus problems
- ❑ Hoarseness
- ❑ Any other problems not listed

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Please list all of your present medical problems and doctors you are seeing: _____

_____

_____

_____

Please list all past medical problems, operations, and hospital admissions: _____

_____

_____

_____

Please list your allergies, if any: _____

_____

Height: _____ Weight: _____

Amounts per day:

Alcohol: _____ Coffee: _____ Tea: _____ Tonic/Soda: _____ Water: _____

If you smoke, how much: _____ Recreational Drugs: ❑ Yes ❑ No

What time do you go to sleep and wake up? Weekdays: _____ Weekends: _____

Physical exercise / frequency / duration: _____

Present work status: _____ Do you like your job: ❑ Yes ❑ No ❑ Not Sure

If you have children, please list their ages: _____

Please list hobbies / recreational activities: _____

What is you current level of stress (0 = no stress, 10 = catastrophic): _____

Level of education: _____ Do you have pets: ❑ Yes ❑ No

With whom are you living with (list relationship and age): _____

Are there any serious problems at home: ❑ Yes ❑ No, if yes describe: _____

Is there a family history of (check all that apply):

❑ Headaches	❑ Heart Disease	❑ Alcoholism	❑ Tuberculosis	❑ Excessive Bleeding
❑ Seizures	❑ High Blood Pressure	❑ Goiter/Thyroid	❑ Mental Illness	❑ Cancer
❑ Strokes	❑ Arthritis	❑ Diabetes	❑ Obesity	❑ Sleep Disorders

❑ Other: _____

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