

Appendix A; Headache Data Collection Form

Name: _____ Date: _____
Date of Birth: _____ Dr. _____

General and Aura:

How old were you when you started to suffer from headaches?

<25 years +20 years +55 years

Do you have any warning symptoms (1-24 hours before pain onset): elation/irritability, depression, drowsiness, hunger, or thirst?

Yes No

Do symptoms (such as visual disturbance, pins and needles, numbness, disturbed speech, confused thinking, dizziness, decreased hearing, noise in the ears, double vision, and/or incoordination) typically come a few minutes before a headache?

Yes No

The Headache

What kind of pain is it?

**Pressure/tightening throbbing/pulsating burning
stabbing/boring bursting Other**

Is the headache usually so severe as to stop you from performing your usual activities?

Yes No

Time characteristics

How many days of work or school have you missed *in the last month* because of headache?

0 1 2 3 4 5 6 7 8 9 10 11 12 13
14 15 >15

About how often do you have this type of headache each year?

<24/year >24/year >90/year Daily

How long does the headache last without medication or if it does not work?

1-4 hours 4-72 hours >72 hours

How long does it take to develop?

Instantaneously Within minutes 10-60 minutes Slowly

Do the headaches occur in clusters lasting weeks?

Yes No

In the last 6 months, have you had a headache for at least 15 days a month?

Yes No

Does the headache usually start at the same time?

Night On waking Evening No

Are there days during the week on which you have a headache more often?

Yes No

For women only: Are there days in the month on which you have headaches more often?

Yes No

Has pregnancy affected your headaches?

Yes No

Spatial characteristics

Where in your head do you feel the pain?

Eye Forehead Temples Back of head All over/all round Not localized

Do you feel pain on one side or on both?

One Both

If on one side, is it always on the same side?

Yes No

If on both sides, does the pain start on one side?

Yes No

Precipitants

Do any factors precipitate a headache? (please circle those that do) certain foods odors changes in weather time of year loss of sleep allergens menses flicker/glare sleep excess jaw clenching relaxation after stress sexual activity hunger neck movement exercise smoking fatigue emotion stress eyestrain

Chemicals such as:

Caffeine ergot marijuana phenothiazines reserpine lead Vitamin A oral contraceptive pills SSRIs amphetamines Indomethacin levadopa clomiphene hydralazine histamine Alcohol

Do you need to take pain-relieving medications:

Less than 2 days/week 3-5 days/week 6-7 days/week

Aggravants, relievants, and associated symptoms:

Do you find that you cannot keep still during a headache?	YES	NO
Do activities like walking up stairs make the headache worse?	YES	NO
Does bending or coughing worsen the headache?	YES	NO
Do you avoid even slight movements during a headache?	YES	NO
Does sleep (if possible during a headache) usually relieve it?	YES	NO

During a headache:

Are you unusually sensitive to light and try to avoid it?	YES	NO
Are you usually sensitive to noise and try to avoid it?	YES	NO
Do you feel nauseated?	YES	NO
Do you vomit?	YES	NO
Do you experience; irritability, hyperactivity, inability to think/concentrate, food cravings, mood variations, aversion to odors, or increased sense of smell?	YES	NO
Does your eye water on the painful side?	YES	NO
Does your nose plug up or run on the painful side?	YES	NO
Do your face and forehead sweat on the painful side?	YES	NO
Does the pupil become smaller on the affected side?	YES	NO
Does your eyelid close on the painful side?	YES	NO

Are any other symptoms associated with the actual headache, such as:

loss of vision in one eye, loss of vision to one side, pallor, double vision, vertigo (spinning dizziness), seizures, difficulty in saying words, confused thinking, faintness, loss of memory tingling, (pins and needles in the face/limbs), weakness of one arm/leg, incoordination, face swelling, numbness in one arm/leg, shortness of breath, palpitations,

Other Factors

Do any members of your family suffer from similar headaches?

Yes No

Did you get travel sickness or unexplained stomach pains as a child?

Yes No

Do you ever have ice-pick pains?

Yes No

Do you have other type(s) of headache besides the one you have described?

Yes No

(please describe on a new form)

What medications have you ever taken for an acute headache? (please circle)

ASA Acetaminophen Oxygen Fiorinal NSAIDs/Toradol DHE
Codeine Xylocaine Imitrex injection Imitrex Nasal Spray Imitrex
tablets Zomig tablets Zomig Nasal Spray Relpax Maxalt Frova
Axert Amerge Migrainal Demerol

What medications have you ever taken to prevent headaches? (please circle)

Steroids Chlorpromazine Lithium Pizotifen Topamax
Methysergide Depakote Cyproheptadine Tricyclics
MAOIs Beta-blocker Ca⁺ channel blocker

Past Health (please circle any you have suffered)

Head injury Neck injury/arthritis Allergies Hypertension Blood disorder
Seizures Sinus disease Dental diseases Neck injury Stroke
Jaw/joint problems Eye/ear problems Meningitis Asthma Heart problems