DR JULIAN RODRIGUES
NEUROLOGIST

HEADACHE QUESTIONNAIRE

PERSONAL DETAILS

Surname

Given name(s)

Date of birth / /

Gender

Marital status

Children/Dependents

HEADACHE/MIGRAINE HISTORY

Age when migraines first started

How many migraines do you experience per month on average?

How many regular headaches do you have per month on average?

How long do your migraine headaches usually last after you take your medications?

- [ ] No more than 2 hours
- [ ] 3-4 hours
- [ ] 5-12 hours
- [ ] 12-24 hours
- [ ] Several days
- [ ] 1 week or longer

How long do your migraine headaches usually last if you DO NOT take your medications?

- [ ] No more than 2 hours
- [ ] 3-4 hours
- [ ] 5-12 hours
- [ ] 12-24 hours
- [ ] Several days
- [ ] 1 week or longer

Where are your migraine headaches usually located? (select all that apply)

- [ ] Above/Behind the Eye — [ ] Right [ ] Left [ ] Both
- [ ] Temporal Area — [ ] Right [ ] Left [ ] Both
- [ ] Occipital/Back of Head — [ ] Right [ ] Left [ ] Both
- [ ] Other

Which area is most affected?

How would you describe your migraine headaches?

- [ ] Throbbing/pounding
- [ ] Ache/pressure
- [ ] Ice pick
- [ ] Dull
- [ ] Other

Do your migraine headaches wake you at night?

- [ ] Never
- [ ] Occasionally
- [ ] Often

Do you have an aura or any warning signs prior to a migraine headache?

- [ ] No
- [ ] Yes

Do any of the following occur before or during your migraine headaches? (Check all that apply)

- [ ] Nausea
- [ ] Vomiting
- [ ] Diarrhoea
- [ ] Bothered by light/noise
- [ ] Blurred/double vision
- [ ] Sparkling/Flashing/Coloured light
- [ ] Eyelid puffy
- [ ] Eyelid droops
- [ ] Loss of vision
- [ ] Feeling lightheaded
- [ ] Numbness/tingling
- [ ] Weakness of arm or leg
- [ ] Difficulty concentrating
- [ ] Speech difficulty
- [ ] Runny nose
- [ ] Other

Do any of the following bring on your migraine headaches or make them worse?

- [ ] Stress (worry, anger)
- [ ] Bright Sunshine
- [ ] Weather Changes
- [ ] “Letdown” after stress
- [ ] Loud Noise
- [ ] Heavy Lifting
- [ ] Air Travel
- [ ] Covid-19 infection
- [ ] Fatigue
- [ ] Covid-19 vaccine
- [ ] Missed meals
- [ ] Certain smells or perfume
- [ ] Sexual Activity
- [ ] Coughing, straining, bending over
- [ ] Certain food (Chocolate, cheese, beer, MSG)
- [ ] Other

FORM CONTINUES OVER PAGE ▶

Do any of the following make your migraine headaches better?

- ☐ Rest
- ☐ Exercise
- ☐ Quiet and darkness
- ☐ Hot and Cold compress
- ☐ Massage
- ☐ Warm shower
- ☐ Pressure over migraine headache area
- ☐ Other

If you are female, do your migraine headaches change with the following?

- ☐ Menstrual periods
- ☐ Birth control pills
- ☐ Pregnancy
- ☐ Other

List all past treatments for your migraine headaches:

- ☐ Medication
- ☐ Nerve Block
- ☐ Botox
- ☐ IV Med
- ☐ CGRP Blocker

What kind of relief did you get?

- ☐ Complete
- ☐ Partial
- ☐ None

How long did the relief last?

How many days in the last 3 months have you missed work or school due to your migraine headaches?

How many days in the last 3 months did you not do household work due to your migraine headaches?

To what extent do your migraine headaches affect your quality of life?

- ☐ Extremely
- ☐ Moderately
- ☐ Very Little
- ☐ Not at all

FAMILY HISTORY

Do any of your family members have migraine headaches?

- ☐ No
- ☐ Yes

If yes, please give details:

MEDICAL HISTORY

Please list your current medications:

Name	Dose

Please list any allergies:

Do you smoke?

- ☐ No
- ☐ Yes

Drink alcohol?

- ☐ Never
- ☐ Sometimes
- ☐ Often

Have you ever been diagnosed with the following?

- ☐ Stroke/Aneurysm
- ☐ Seizures
- ☐ Intracranial hyper/hypotension
- ☐ Brain/spine tumour
- ☐ Eye condition/visual field defect
- ☐ Sleep apnoea/snoring
- ☐ Teeth clenching, jaw problems
- ☐ Other condition of brain, spine or nerves

Are you currently receiving treatment for any of the above conditions? If yes, give details.

Have you ever had a head or a neck injury requiring medical treatment?

- ☐ No
- ☐ Yes

If yes, provide details (nature of injury, date of injury, treatment)

FORM CONTINUES OVER PAGE ▶

Have you ever seen a pain specialist?

☐ No ☐ Yes

If yes, provide details (condition, date of last treatment)

Have you ever been treated for a psychiatric condition?

☐ No ☐ Yes

If yes, provide details (condition, date of last treatment)

Have you had your migraine headaches managed by a neurologist?

☐ No ☐ Yes (If yes, provide details)

Name	Year

What was the diagnosis?

☐ Migraine Headache
☐ Tension-type
☐ Cluster
☐ Other

Please select any tests you have had in the past

	Where	Year
☐ MRI Brain/Neck		
☐ CT Head/Neck		
☐ Angiogram		
☐ EEG		
☐ Sleep study		
☐ Eye exam		
☐ Lumbar puncture		
☐ Other		
If other, specify		

CLEAR FORM