# Headache Questionnaire

Do you have a headache today? Yes No Intensity: 0-1-2-3-4-5-6-7-8-9-10

Age of onset: _____

Trauma related? Yes No

Menstrual cycle related? Yes No Age of onset of menstrual cycle: _____

**Triggers:**

Food Yes No Explain: _____

Allergies Yes No Explain: _____

Weather Yes No Explain: _____

Stress Yes No Explain: _____

**Description:**

Average intensity: 0-1-2-3-4-5-6-7-8-9-10

Frequency? _____

How long do they last? _____

Mild headaches _____

How functional are you during headaches? _____

How much work do you miss related to headaches? _____

Light sensitivity Yes No

Sound sensitivity Yes No

Odor sensitivity Yes No

Nausea and/or vomiting Yes No

**Treatment:**

MRI/CT Yes No Explain: _____

ER visits: _____

What do you do for them now? _____

**Medications:**

Current:_____

_____

Previous:_____

_____