Patient Name: _____ Date: _____

Age of onset of headache:
Circumstances around the onset of headache:
Recent change in headache:
Present Frequency of headaches: (per month)
Past frequency of headaches:
Prodromes (warning signs before the onset of headache):
Usual time Of Onset of headache:
Mode of Onset (First warning of onset of headache and how the headache develops):
Average Duration of headache:
Shortest Duration of headache:
Longest Duration of headache:
Location of headache:
Usual Average Intensity (**Pain Rating)** **1 2 3 4 5 6 7 8 9 10** No Pain Worst Possible Pain
Quality: (pressure, tightness, stabbing, jabbing, throbbing etc.)
Accompaniments (nausea, vomiting, sensitivity to light or noise, weakness, numbness, loss of consciousness, change in color of face etc.):
Precipitating Factors (periods, certain food, drinks, stress, missing a meal etc):
Aggravating Factors (coughing, sneezing, bending over, noise)
Behavior During Headache (Continue to function with daily routine, go and lie down in a dark quiet room, put cold cloth on head, pace the floor etc.):
Childhood migraine equivalents (car sickness, sea sickness, or bilious vomiting):
Current Preventive Medications for Headaches (name and doses):
Current Drug Treatment for Headache Attack (name and doses):
Past Drug Treatment of Headache (name and doses):
Non Drug Treatment (relaxation, biofeedback, Acupuncture, Chiropractor, dietary changes etc):
Self Description (cool, calm collected, tense, nervous, worrier, if upset with someone keep feeling inside or can express feelings etc.):
Investigations for headaches: such as CT scan, MRI :
Menstrual History Last Menstrual Period: PAP Test: Mammogram: Use hormone pill?

Marital status:
Name of spouse:
Age:
Health:

Family History:	Age	Town of residence	Health	Headache history (Yes/No)
Father				
Mother				
Sibling 1				
Sibling 2				
Sibling 3				
Child 1				
Child 2				
Child 3				

Effect of headache on:

Yourself	Family	Work	Social life

Any other information you would like to provide: