

# HEADACHE (MIGRAINE) QUESTIONNAIRE

Please fax back to IPA at 781-643-2775

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1. When did your headaches first start? \_\_\_\_\_
2. When was your last attack? \_\_\_\_\_
3. How often do your headaches occur? \_\_\_\_\_
4. Are they intermittent \_\_\_\_\_ continuous \_\_\_\_\_ brief \_\_\_\_\_ prolonged \_\_\_\_\_
5. Which part of your head is usually affected?  
Front \_\_\_\_\_ Back \_\_\_\_\_ Top \_\_\_\_\_ Sides \_\_\_\_\_
6. Are your headaches associated with certain foods such as chocolate, coffee and so on? \_\_\_\_\_
7. Are there any other associated symptoms or signs affecting? (yes or no)
  - a. Vision, vision fields or double vision \_\_\_\_\_
  - b. Numbness or tingling \_\_\_\_\_
  - c. Muscle weakness \_\_\_\_\_
  - d. Nausea, vomiting \_\_\_\_\_
  - e. Dizziness, hearing loss \_\_\_\_\_
  - f. Unsteadiness of gait or limbs, staggering \_\_\_\_\_
  - g. Undue sleepiness \_\_\_\_\_
  - h. Kidney disorder \_\_\_\_\_
  - i. High blood pressure \_\_\_\_\_
  - j. Have fits or explosive behavior \_\_\_\_\_
8. Is there any relationship between your headaches and any of the below:
  - a. Nervous tension \_\_\_\_\_
  - b. Allergies \_\_\_\_\_
  - c. Medications \_\_\_\_\_
  - d. Menstrual cycle \_\_\_\_\_
9. Have you had any special diagnostic testing done for your headaches, if so, when and what procedures were done? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Who is your physician? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. What treatment has been prescribed? \_\_\_\_\_  
What is your current diagnosis? \_\_\_\_\_

Agent Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax No: \_\_\_\_\_

Date: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Please circle the associate you work with. Russ, Rhonda, Leo