

Brain and Spine Center, P.L.C. 4045 W. Chandler Blvd. Bldg. F Chandler, Arizona 85226 1760 E. Florence Blvd. Suite 250 Casa Grande, AZ 85122 Office (480) 917-3706 Fax (480) 353-2066

Headache Questionnaire

Patient Name:					Date:/		
How many headaches do 1-4 5-10	you average in 11-14	a month? 15≥	Duration 1-5	n of head 6-10	aches in hou 10-14	urs: 15≥	
How many migraines do 1-4 5-10	you average in 11-14	n a month? Duration of migr 15≥ 1-5 6-10			aine in hour 10-14	rs: 15≥	
Do you experience any of	the following s	ymptoms when	you have a r	nigraine?	(Circle all	that apply)	
Nausea/Vomiting		Vision Changes Numbness/I			Fingling		
Light/sound/smell sensitiv	rity D	Pizziness	Tinnitus (ringing in ears))	
Worse pain with bending/	Pair	Pain relieved with lying down					
Indicate which of the followhy you stopped. (E.g Pro							
Amitriptyline		Aimovig			Nimodipine		
Nortriptyline (Pamelor)		Emgality			Metoprolol		
Protriptyline		Topamax (Topiramate)			Timolol		
Citalopram (Celexa)		Valproic Acid (Depakote)			Atenolol		
Doxepin		Divalproex Sodium			Nadolol		
Fluoxetine (Prozac)		Gabapentin (Neurontin)			Propranolol		
Fluvoxamine		Enalapril			Candesartan		
Mirtazapine		Lisinopril			Valsartan (Diovan)		
Paroxetine (Paxil)		Ramipril			Losartan		
Sertraline (Zoloft)		Verapamil			Olmesartan		
Venlafaxine (Effexor)		Amlodipine			Ibesartan		
Ajovy Nifedipine Patient Name:				Date	• /	/	



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Headache Questionnaire

Please answer a fortreatment.	ew follow up q	uestions about	your headache	es and/or migraines since starting			
How many heada	aches per mont	h have you had	since starting	the medication?			
0-4	5-10	10-14	15≥				
Has the frequency	y and/or duratio	on of your head	aches decrease	ed since starting the medication?			
Yes (If yes, by how much?)				No			
Has the intensity	of your headac	hes decreased s	ince starting th	ne medication?			
Yes (If yes, by how much?)				No			
Any side effects r	related to the m	edication? If ye	es, please list.				
How many migraines per month have you had since starting the medication?							
0-4	5-10	10-14	15≥				
Has the frequency	y and/or duratio	on of your migra	aines decrease	d since starting the medication?			
Yes (If ye	s, by how much	No					
Hs the intensity o	f your migraine	es decreased sin	nce starting the	e medication?			
Yes (If yes, by how much?)				No			
How many times migraine such as	•			(Medication to STOP or lessen the			
0-2	3-6	7-9					
Any side effects r	elated to the m	edication? If ye	es, please list.				