BRAIN & SPINE CENTER
MEMORY CLINIC
Diagnose Modify Treat

Brain and Spine Center, P.L.C.

4045 W. Chandler Blvd. Bldg. F • Chandler, Arizona 85226 | 1760 E. Florence Blvd. Suite 150 • Casa Grande, AZ 85122
Office (480) 917-3706 Fax (480) 353-2066

HEADACHE QUESTIONNAIRE

Patient name: _____ **Date:** _____

How many headaches do you average in a month?

☐ 1-4 ☐ 5-10 ☐ 11-14 ☐ 15≥

Duration of headaches in hours:

☐ 1-5 ☐ 6-10 ☐ 10-14 ☐ 15≥

How many migraines do you average in a month?

☐ 1-4 ☐ 5-10 ☐ 11-14 ☐ 15≥

Duration of migraine in hours:

☐ 1-5 ☐ 6-10 ☐ 10-14 ☐ 15≥

Do you experience any of the following symptoms when you have a migraine?

☐ Nausea/Vomiting ☐ Vision changes ☐ Numbness/Tingling ☐ Light/sound/smell sensitivity
☐ Dizziness ☐ Tinnitus (ringing in ears) ☐ Worse pain with bending/coughing/sneezing
☐ Pain relieved with lying down

Indicate which of the following medications have been tried in the past, length of time you were on it, and why you stopped. *(E.g. Propranolol for 6 months, did not help headaches or caused dizziness)*

☐ Amitriptyline
☐ Nortriptyline (Pamelor)
☐ Protriptyline
☐ Citalopram (Celexa)
☐ Doxepin
☐ Fluoxetine (Prozac)
☐ Fluvoxamine
☐ Mirtazapine
☐ Paroxetine (Paxil)
☐ Sertraline (Zoloft)
☐ Venlafaxine (Effexor)
☐ Ajovy
☐ Aimovig
☐ Emgality
☐ Topamax (Topiramate)
☐ Valproic Acid (Depakote)
☐ Divalproex Sodium
☐ Gabapentin (Neurontin)
☐ Enalapril
☐ Lisinopril
☐ Ramipril
☐ Verapamil
☐ Amlodipine
☐ Nifedipine
☐ Nimodipine
☐ Metoprolol
☐ Timolol
☐ Atenolol
☐ Nadolol
☐ Propranolol
☐ Candesartan
☐ Valsartan (Diovan)
☐ Losartan
☐ Olmesartan
☐ Ibesartan

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HEADACHE QUESTIONNAIRE

*Please answer a few **follow up** questions about your headaches and/or migraines since starting treatment.*

How many headaches per month have you had since starting the medication?

☐ 0-4 ☐ 5-10 ☐ 10-14 ☐ 15≥

Has the frequency and/or duration of your headaches decreased since starting the medication?

☐ Yes (If yes, by how much? _____) ☐ No

Has the intensity of your headaches decreased since starting the medication?

☐ Yes (If yes, by how much? _____) ☐ No

Any side effects related to the medication? If yes, please list.

_____

_____

_____

How many migraines per month have you had since starting the medication?

☐ 0-4 ☐ 5-10 ☐ 10-14 ☐ 15≥

Has the frequency and/or duration of your migraines decreased since starting the medication?

☐ Yes (If yes, by how much? _____) ☐ No

Has the intensity of your migraines decreased since starting the medication?

☐ Yes (If yes, by how much? _____) ☐ No

How many times did you have to use your migraine abortive? (Medication to STOP or lessen the migraine such as Ibuprofen, Tylenol, Sumatriptan, etc.)

☐ 0-2 ☐ 3-6 ☐ 7-9

Any side effects related to the medication? If yes, please list.

_____

_____

_____