NorthShore
University HealthSystem

Questionnaire for Headache Patient

Please complete all questions in their entirety to the best of your knowledge. The requested information is essential for the NorthShore University HealthSystem staff in determining the most efficient care plan.

Patient's Name Date of Birth

Headache Information

1. What is the main concern that you would like addressed today?

   _____
   _____
   _____

2. When did headaches begin?

   _____
   _____
   _____

3. How frequent are headaches (daily, weekly, monthly)?

   _____
   _____
   _____

4. Do you experience light sensitivity? Yes or No
5. Do you experience sound sensitivity? Yes or No
6. What time of day do headaches usually begin?

   _____
   _____
   _____

7. Do you experience nausea or vomiting with headaches? Yes or No
8. Have you experienced any other symptoms? Yes or No If so, please explain:

   _____
   _____
   _____

9. Do you have any known triggers, such as stress, dehydration, certain foods or exercise? Yes or No If so, please explain:

   _____
   _____
   _____

10. What treatments/medications have you tried (please include dosage)? Do they work?

    _____

_____
_____

11. Do you miss school due to your headaches? Yes or No
12. Do you skip meals? Yes or No
13. How much water do you drink a day?

_____
_____
_____

Past History: Have you previously seen a neurologist for this issue? Yes or No

Has previous brain imaging (MRI or CT) been performed? Yes or No

Sleep schedule: What time do you go to sleep?

_____
_____
_____

What time do you wake up?

_____
_____
_____

Night awakenings? Yes or No