New Patient Questionnaire: Headache, Facial Pain and Dizziness
(Estimated completion time: 10 min)

Patient name: ___________________________________________  Date of visit: __________________________

1. What is the reason for your visit? Check all that apply.
☐ Head pain  ☐ Face pain  ☐ Neck pain  ☐ Dizziness  ☐ Other ______________________

2. Pain characteristics:
How old were you when your first-ever head/face pain started? __________
When did the current headache/face pain start? ____________
What do you attribute your symptoms to?
☐ Head injury  ☐ Infection  ☐ Family history/genetics
☐ After a procedure  ☐ I don’t know  ☐ Other________________________
Current number of head/face pain days per month: ________________
If your headaches/face pain are daily, how many years ago did they become daily? _______
Average duration of headache/face pain attacks in seconds/minutes/hours: ______________
☐ They are daily
Average time from start of headache/face pain to peak intensity (worst pain): ☐ Seconds ☐ Minutes ☐ Hours
Time of day headache starts:
☐ Morning  ☐ Afternoon  ☐ Evening  ☐ During sleep  ☐ All day
Do these symptoms wake you up in the middle of your sleep?
☐ Yes  ☐ No

3. Pain location: Please mark on the diagram below.

4. How would you describe your pain? Check all that apply.
☐ Aching  ☐ Exploding  ☐ Shooting  ☐ Tingling/pins and needles
☐ Burning  ☐ Hot  ☐ Squeezing  ☐ Zapping
☐ Dull  ☐ Pressure  ☐ Throb/pounding/pulsating  ☐ Other: ______________________
☐ Electric  ☐ Sharp  ☐ Thunderclap

5. Rate the average intensity of your head/face pain from 1-5:
☐ (1 = Mild)
☐ (2 = Moderate, uncomfortable – can still work/study, enjoy social activities)
☐ (3 = Severe, interrupts work/study, house chores)
☐ (4 = Incapacitating, unable to work/study)
☐ (5 = Most extreme, unimaginable, bedridden)
6. What are your triggers? Check all that apply.

☐ Air travel/long-distance car travel  ☐ Exercise/exertion  ☐ Straining on the toilet
☐ Alcohol  ☐ Flashing lights  ☐ Strong smell
☐ Brushing teeth  ☐ Light touch  ☐ Sudden neck movements
☐ Certain foods  ☐ Makeup  ☐ Too little sleep
☐ Chewing  ☐ Missing meals  ☐ Too much sleep
☐ Cold/hot wind on face  ☐ Sexual intercourse/orgasm  ☐ Weather changes
☐ Coughing  ☐ Shaving  ☐ Weekend let down
☐ During/around menses (period)  ☐ Sneezing  ☐ Other: ________________________________

7. What other symptoms do you have during headache/face pain? Check all that apply.

☐ Arm numbness  ☐ Fainting  ☐ Sensitivity to light
☐ Arm weakness  ☐ Leg numbness  ☐ Sensitivity to smell
☐ Avoid physical activity because it makes symptoms worse  ☐ Leg weakness  ☐ Sensitivity to sound
☐ Confusion  ☐ Motion sickness  ☐ Slurred speech
☐ Difficulty getting words out  ☐ Nausea  ☐ Stuffy or runny nose
☐ Ear fullness/clogging feeling  ☐ Pacing/restlessness  ☐ TMJ dysfunction/pain
☐ Eye droop  ☐ Ringing in ears  ☐ Vomiting
☐ Face flushing  ☐ Scalp soreness to touch  ☐ Watery eyes
☐ Face pain  ☐ Seizure  ☐ Other: ________________________________

8. Questions about positional component:

What happens to your headache when you stand up?  ☐ No change  ☐ Better  ☐ Worse
What happens to your headache when you lay down flat?  ☐ No change  ☐ Better  ☐ Worse

9. Do you have visual symptoms with your headaches? ☐ Yes  ☐ No (If no, move to next question)

If yes, how long do they last?  ____ minutes  ____ hours  ____ days  ____ on and off throughout the day

Which vision pattern do you see? Check all that apply.

☐ Arc shape  ☐ Blind/white/black spots  ☐ Cloud  ☐ Kaleidoscope  ☐ Other: ____________
☐ Blurred vision  ☐ Checkerboard pattern  ☐ Double vision  ☐ Tunnel vision

10. Did you feel dizzy in the last 4 weeks? ☐ Yes  ☐ No (If no, move to next question)

If yes, describe the feeling:  ☐ Lightheaded when standing up  ☐ Imbalance/being on a boat feeling
☐ Vertigo (room spinning)  ☐ Other (explain): ________________________________

How long does the dizziness last?  ☐ Constant  ☐ Comes and goes

If it comes and goes, what is the duration of the longest and shortest attacks? Give a range: _____________________

Is dizziness attack triggered by body position change? ☐ Yes  ☐ No

Do you have any of the following symptoms associated with dizziness?

☐ Feeling of passing out  ☐ Feeling warm, sweaty, clammy  ☐ Hearing loss  ☐ Heart palpitations  ☐ Ringing in ears
11. Do you have other ongoing active symptoms? Check all that apply.
☐ Abdominal pain  ☐ Feeling tired most of the day  ☐ Prolonged bleeding
☐ Arms/legs shaking  ☐ Fever  ☐ Recurrent infections
☐ Bloody stool  ☐ Hearing loss  ☐ Restricted motion
☐ Chest pain  ☐ Heartburn  ☐ Sensation of sand in eyes
☐ Chills  ☐ Heat/cold intolerance  ☐ Shortness of breath
☐ Constipation  ☐ Hyper-flexible joints  ☐ Skin rash/growth
☐ Cough  ☐ Insomnia  ☐ Snoring
☐ Diarrhea  ☐ Irregular/painful periods  ☐ Spells of loss of consciousness
☐ Difficulty controlling  ☐ Joint pain  ☐ Swelling in legs/joints
bladder/bowel movements  ☐ Lump/mass anywhere  ☐ Unexplained weight loss
☐ Dry eyes  ☐ Muscle aches
☐ Dry mouth  ☐ Easy bruising  ☐ Palpitations/irregular heartbeat

12. Do you have another medical diagnosis? Check all that apply.
☐ ADHD  ☐ CSF leak  ☐ Lupus
☐ Anxiety  ☐ Dementia  ☐ Obstructive sleep apnea
☐ Arnold-Chiari  ☐ Depression  ☐ Pancreatitis
☐ Asthma  ☐ Diabetes  ☐ POTS
☐ Atrial fibrillation  ☐ Diverticulitis  ☐ PTSD
☐ Bipolar disorder  ☐ Ehlers Danlos Syndrome  ☐ Pseudotumor cerebri/idiopathic intracranial hypertension
☐ BPPV  ☐ Fibromyalgia  ☐ Sarcoidosis
☐ Brain aneurysm  ☐ Giant cell arteritis  ☐ Schizophrenia
☐ Brain hemorrhage  ☐ Glaucoma  ☐ Seizures/epilepsy
☐ Brain tumor  ☐ Heart attack  ☐ Stomach ulcer
☐ BPPV  ☐ Hypertension  ☐ Stroke
☐ Cancer (type: __________)  ☐ Interstitial cystitis  ☐ Thyroid disease
☐ Chronic fatigue syndrome  ☐ Irritable bowel syndrome  ☐ Traumatic brain injury
☐ Chronic kidney disease  ☐ Kidney stones  ☐ Trigeminal neuralgia
☐ Clot in legs/lungs  ☐ Liver disease/Hepatitis  ☐ Vasculitis
☐ Concussion  ☐ Lyme disease

13. List any other medical conditions and the year of diagnosis:
a) _______________________________             Year: ______
c) _______________________________             Year: ______
b) _______________________________             Year: ______
d) _______________________________             Year: ______

14. List all previous surgeries including the year:
a) _______________________________             Year: ______
c) _______________________________             Year: ______
b) _______________________________             Year: ______
d) _______________________________             Year: ______

15. List any other medical problems in your family: ___________________________________________
Headache sufferer in your family? _______________ Family history of brain aneurysms?  ☐ No  ☐ Yes

16. Miscellaneous questions:
Weight gain in last 6 months?  ☐ No  ☐ Yes  If yes, how many pounds? ______

Days per month missed from work or school within last 6 months? ______  ☐ N/A (Disabled)

Do you have neck pain?  ☐ No  ☐ Yes  If yes, how many days per week? ______

Do you have pain elsewhere?  ☐ No  ☐ Yes  If yes, where? _______________________________________________

Using birth control?  ☐ No  ☐ Yes  If yes, what type?  ☐ Condoms ☐ IUD ☐ Pills ☐ Skin implant ☐ Other

Current stressors?  ☐ Job  ☐ School  ☐ Relationship  ☐ Finance  ☐ Sick family member  ☐ Recent death of loved one
  ☐ Ongoing medical problems  ☐ None  ☐ Other: _______________________________________________

History of abuse ever?  ☐ No  ☐ Yes  If yes, what type?  ☐ Physical  ☐ Emotional  ☐ Sexual  ☐ Verbal
  ☐ Flashbacks of witnessed traumatic incident

History of motion sickness as a child?  ☐ No  ☐ Yes

History of head or neck trauma/concussion?  ☐ No  ☐ Yes  If yes, explain: _______________________________________

Ever had loss of consciousness?  ☐ No  ☐ Yes  If yes, explain: _____________________________________________

Which headache/dizziness/face pain specialists have you been to before? ___________________________________

Have you ever been treated at a drug/opiate/alcohol rehab facility?  ☐ No  ☐ Yes

17. Social/demographic questions:
Have you ever been a smoker?  ☐ No  ☐ Yes

Do you currently smoke?  ☐ No  ☐ Yes

How many caffeinated beverages per day? _____  If yes, name what kind: _______________

Do you drink alcohol?  ☐ No  ☐ Yes  If yes, how many alcohol drinks per week? ______

Do you use recreational/street drugs currently?  ☐ No  ☐ Yes (marijuana, LSD, psychedelic mushrooms, cocaine)
  ☐ Other (please name): ___________________________________

How many days per week do you exercise? ______

What is your marital status? ____________________________

What is your profession? ______________________________

What is your work status?
  ☐ Full-time  ☐ Part-time  ☐ Homemaker  ☐ Retired  ☐ Student  ☐ Disabled (please explain): _______________________

18. Over the last 3 weeks, how often have you experienced the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having little interest or pleasure in doing things</td>
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<tr>
<td>Feeling down, depressed or hopeless</td>
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<td>Feeling tired or having little energy</td>
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<td>Having a poor appetite or overeating</td>
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<td>Feeling bad about yourself (or that you are a failure or have let yourself or your family down)</td>
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<td>Thinking about suicide or hurting yourself</td>
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<td>Feeling nervous, anxious or on edge</td>
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<td>Not being able to stop or control worrying</td>
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<tr>
<td>Being so restless that it’s hard to stay still</td>
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<tr>
<td>Becoming easily annoyed or irritable</td>
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<tr>
<td>Feeling afraid as if something awful might happen</td>
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</tbody>
</table>
19. Within the last 12 months, have you used any of the following drugs for pain? Circle all that apply.

<table>
<thead>
<tr>
<th>Nonsteroidal anti-inflammatory drugs (NSAIDs):</th>
<th>How many days per week?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ibuprofen (Advil), Naproxen (Aleve),</td>
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<tr>
<td>Celecoxib (Celebrex), Ketorolac (Ketorolac),</td>
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<td>Diclofenac (Voltaren, Cambia), Aspirin,</td>
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<tr>
<td>Indomethacin (Indocin), <strong>Goody's powder</strong>,</td>
<td></td>
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<tr>
<td><strong>Meloxicam</strong></td>
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<tr>
<td><strong>Triptans/ergot alkaloids:</strong> Sumatriptan, (Imitrex), Rizatriptan (Maxalt), Naratriptan (Amerge), Zolmitriptan (Zomig), Eletriptan (Relpax), Frovatriptan (Frova) Almotriptan (Axert), Treximet, DHE injection, Migrahal/Trudhesa (DHE) nasal spray, Methergine pill</td>
<td></td>
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<tr>
<td><strong>Opiates/narcotics:</strong> Hydrocodone (Vicodin, Norco) Fentanyl patch, Tylenol#3, Oxycodone (Percocet), Morphine, Dilaudid, Suboxone, Methadone, Tramadol, Stadol nasal spray, Nucynta, Codeine, Belbuca, Other opiate (please name): ______________</td>
<td></td>
</tr>
<tr>
<td><strong>Other drugs:</strong> Excedrin, Tylenol, Fioricet, Fiorinal, Midrin, Marijuana, Lasmiditan (Reyvow)</td>
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</table>

20. Have you ever used the following drugs in the past? Circle all that apply.

**Anti-depressants:** Amitriptyline, Nortriptyline (Pamelor), Protriptyline, Venlafaxine (Effexor), Pristiq, Cymbalta, (Duloxetine), Remeron (Mirtazine), Trazodone, SSRIs, Lithium, Abilify, Seroquel, Trazodone, Prozac, Zoloft

**Anti-hypertensives:** Propranolol (Inderal), Nadolol, Metoprolol, Timolol, Carvedilol, Verapamil, Amlodipine, Nifedipine, Nimodipine, Candesartan, Clonidine patch, Lisinopril, Losartan, Lasix

**Anti-seizure class:** Topiramate (Topamax), Trokendi, Gabapentin, Lyrica, Zonisamide, Lamotrigine (Lamictal), Valproate (Depakote), Dilantin (Phenytoin) **Carbamazepine (Tegretol)**, Oxcarbazepine (Trileptal), Eslicarbazepine (Aptiom), Keppra, Clonazepam, Xanax, Valium, Diamox (Acetazolamide)

**Muscle relaxants:** Baclofen, Flexeril, Robaxin, Skelaxin, Tizanidine, Soma, Lorzone

**Anti-CGRP drugs:** Aimovig, Ajovy, Emgality, Nurtec, Ubrelvy, Qulipta

**Steroids:** Prednisone, Dexamethasone, Cortisone, Fludrocortisone, Hydrocortisone

**Miscellaneous drugs:** Memantine (Namenda), Zofran, Hydroxyzine, Warfarin, Xarelto, Naltrexone, Ritalin (amphetamine), Compazine, Meclizine

**Supplements:** Vitamin B2 (Riboflavin), Magnesium, CoQ10, Butterbur, Feverfew, Gliacin

**Intravenous (IV) infusions:** DHE, Ketamine or Ketamine nasal spray, Lidocaine, Vyepti, (IV Reglan, Toradol, Benadryl)

Besides the above, are there any other drugs that you have tried for headaches/face pain/dizziness?

If yes, explain: ________________________________________________________________________________________________

21. Have you used the following devices? Check all that apply.
☐ Cefaly  ☐ Gamma core (Vagus nerve stimulator)  ☐ TENS unit  ☐ Nerivio migra wearable arm band device

22. Have you ever had the following procedures? Check all that apply.
☐ Botox  ☐ Psychotherapy
☐ Fibrin glue patch  ☐ Rhizotomy
☐ Gamma Knife radiosurgery  ☐ SPG (sphenopalatine ganglion block) via nose
☐ Nasal sinus surgery  ☐ Stellate ganglion block
☐ Nerve stimulator implant  ☐ Supraorbital blocks in the forehead
☐ Occipital nerve blocks behind the head  ☐ Trigger point injections
☐ Occipital nerve decompression surgery  ☐ Trigeminal nerve block (for trigeminal neuralgia)
☐ Occipital nerve stimulator implant  ☐ X-ray/fluoroscopy-guided neck blocks (epidural, facet blocks in the neck, radiofrequency ablation)
☐ Physical therapy of head/neck

23. When was the last time you had the following tests? Check all that apply and write the year.
☐ MRI/MR Angio Brain  Year: ______  ☐ CT Head/CT Angio Head  Year: ______
☐ MRI Neck  Year: ______  ☐ MR/CT Venogram Head  Year: ______
☐ Lumbar Puncture  Year: ______  ☐ Blood Patch  Year: ______

24. Is there anything else you want to add?
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________

25. Is there any ongoing litigation pertinent to your current medical complaints?  ☐ Yes  ☐ No

Person completing form: __________________________