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? _____

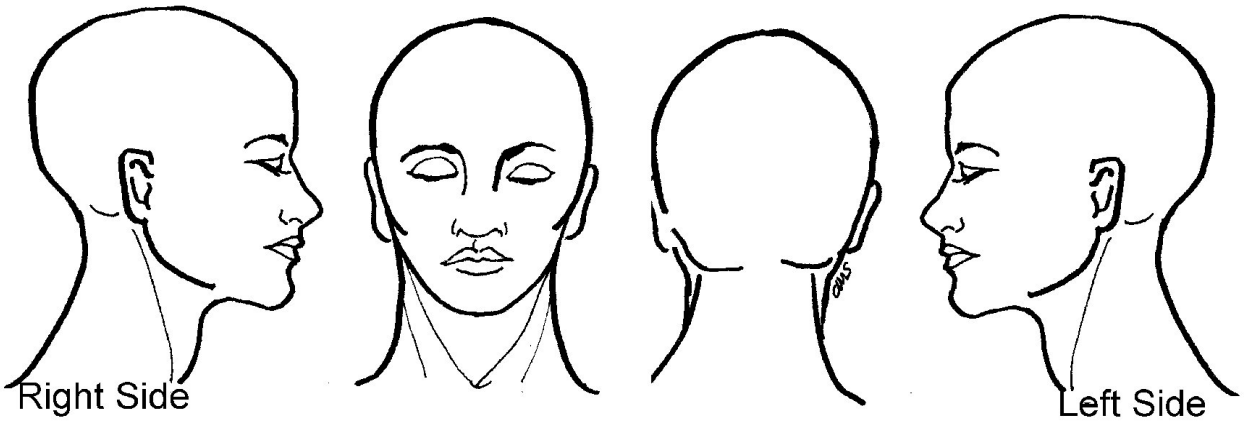
Average duration of headache/face pain attacks in seconds/minutes/hours: _____ ☐ They are daily

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

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

☐ Arm numbness
☐ Arm weakness
☐ Avoid physical activity because it makes symptoms worse
☐ Confusion
☐ Difficulty getting words out
☐ Ear fullness/clogging feeling
☐ Eye droop
☐ Face flushing
☐ Face pain
☐ Fainting
☐ Leg numbness
☐ Leg weakness
☐ Motion sickness
☐ Nausea
☐ Pacing/restlessness
☐ Ringing in ears
☐ Scalp soreness to touch
☐ Seizure
☐ Sensitivity to light
☐ Sensitivity to smell
☐ Sensitivity to sound
☐ Slurred speech
☐ Stuffy or runny nose
☐ TMJ dysfunction/pain
☐ Vomiting
☐ Watery eyes
☐ 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 **(<u>If no</u>, <u>move to next question</u>)**

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 (**<u>If no</u>**, <u>move to next question</u>)

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
- ☐ Arms/legs shaking
- ☐ Bloody stool
- ☐ Chest pain
- ☐ Chills
- ☐ Constipation
- ☐ Cough
- ☐ Diarrhea
- ☐ Difficulty controlling bladder/bowel movements
- ☐ Dry eyes
- ☐ Dry mouth
- ☐ Easy bruising
- ☐ Feeling tired most of the day
- ☐ Fever
- ☐ Hearing loss
- ☐ Heartburn
- ☐ Heat/cold intolerance
- ☐ Hyper-flexible joints
- ☐ Insomnia
- ☐ Irregular/painful periods
- ☐ Joint pain
- ☐ Lump/mass anywhere
- ☐ Muscle aches
- ☐ Palpitations/irregular heartbeat
- ☐ Prolonged bleeding
- ☐ Recurrent infections
- ☐ Restricted motion
- ☐ Sensation of sand in eyes
- ☐ Shortness of breath
- ☐ Skin rash/growth
- ☐ Snoring
- ☐ Spells of loss of consciousness
- ☐ Swelling in legs/joints
- ☐ Unexplained weight loss

12. Do you have another medical diagnosis? Check all that apply.

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

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 <u>3 weeks</u>, how often have you experienced the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Having little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Having a poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself (or that you are a failure or have let yourself or your family down)	☐	☐	☐	☐
Thinking about suicide or hurting yourself	☐	☐	☐	☐
Feeling nervous, anxious or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Being so restless that it's hard to stay still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐

Having racing thoughts that you have difficulty stopping	☐	☐	☐	☐

19. Within the last 12 months, have you used any of the following drugs for pain? Circle all that apply.

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

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 (Mirtazapine), 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 <u>any other drugs</u> 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
☐ Fibrin glue patch
☐ Gamma Knife radiosurgery
☐ Nasal sinus surgery
☐ Nerve stimulator implant
☐ Occipital nerve blocks behind the head
☐ Occipital nerve decompression surgery
☐ Occipital nerve stimulator implant
☐ Physical therapy of head/neck
☐ Psychotherapy
☐ Rhizotomy
☐ SPG (sphenopalatine ganglion block) via nose
☐ Stellate ganglion block
☐ Supraorbital blocks in the forehead
☐ Trigger point injections
☐ Trigeminal nerve block (for trigeminal neuralgia)
☐ X-ray/fluoroscopy-guided neck blocks (epidural, facet blocks in the neck, radiofrequency ablation)

23. When was the last time you had the following tests? Check all that apply and write the year.

☐ MRI/MR Angio Brain Year: _____
☐ MRI Neck Year: _____
☐ Lumbar Puncture Year: _____
☐ CT Head/CT Angio Head Year: _____
☐ MR/CT Venogram Head 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: _____