

# HEADACHE HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

It may seem strange to ask a person where his headache hurts, but the exact location in the head is important to help us make an accurate diagnosis. Please read through the entire history, then answer each question to the best of your ability and as accurately as possible. If uncertain, leave blank.

## 1. Location

Indicate the area of your head where your headaches seem to be concentrated. Please check those that apply:

- \_\_\_\_\_ A. Always on one side ( R ) \_\_\_\_\_ ( L ) \_\_\_\_\_
- \_\_\_\_\_ B. Alternates
- \_\_\_\_\_ C. Always on both sides
- \_\_\_\_\_ D. Over eyes
- \_\_\_\_\_ E. In eyes
- \_\_\_\_\_ F. Under eyes
- \_\_\_\_\_ G. Between eyes
- \_\_\_\_\_ H. Behind eyes
- \_\_\_\_\_ I. In temples
- \_\_\_\_\_ J. In teeth
- \_\_\_\_\_ K. Over cheeks
- \_\_\_\_\_ L. In top of head
- \_\_\_\_\_ M. In side of head
- \_\_\_\_\_ N. In back of head
- \_\_\_\_\_ O. In neck - back
- \_\_\_\_\_ P. In ears
- \_\_\_\_\_ Q. Other \_\_\_\_\_

## 2. How long have you had these headaches? \_\_\_\_\_

A. They have become:

- \_\_\_\_\_ More Severe
- \_\_\_\_\_ Less Severe
- \_\_\_\_\_ Same Severity
- \_\_\_\_\_ More Frequent
- \_\_\_\_\_ Less Frequent
- \_\_\_\_\_ Same Frequency

B. They occur:

- \_\_\_\_\_ 1. Daily
- \_\_\_\_\_ 2. Weekly
- \_\_\_\_\_ 3. Monthly
- \_\_\_\_\_ 4. Periodic (several headaches followed by period of no headaches, only to recur several months later).

C. They begin:

- 1. Slowly (over 20-30 minutes).
- 2. Abruptly

D. They last:

- 1. Seconds
- 2. Minutes
- 3. Hours
- 4. Days

3. Headaches occur most often: (Please check appropriate blank).

- A. Upon awakening in A.M.
- B. Awakened in A.M. by headache
- C. After getting up
- D. Late morning
- E. Later in day
- F. Late afternoon
- G. In evening
- H. Awaken from sleep about 1-3 hours after going to bed
- I. (In Females) In association with monthly periods
- J. Every day for several days, then no headaches for periods of time
- K. Just before meals
- L. 1-2 hours after meals
- M. Do you ever miss or skip meals and have headaches occur at time of normal meals?
- N. Several hours after missing usual meal hour
- O. Other \_\_\_\_\_

4. Headache pain best described as:

- A. Steady
- B. Pulsating
- C. Throbbing
- D. Shooting (if so, write from where to where) \_\_\_\_\_
- E. Other \_\_\_\_\_

5. Headaches are accompanied by: (Please check Yes or No)

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Blockage or obstruction to breathing through nose.     |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. If headache on only one side, nose obstructs same side |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Both sides   |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Runny nose   |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. If headache on only one side, runny nose on same side. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Both sides   |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Redness and watering of eye                            |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. If headache on only one side, the side of headache     |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Both sides   |

- \_\_\_ \_\_\_ D. Changes in eyesight with headaches
  - \_\_\_ \_\_\_ 1. Flashes of light
  - \_\_\_ \_\_\_ 2. Decreased area of vision (tunnel vision)
  - \_\_\_ \_\_\_ 3. Double vision
- \_\_\_ \_\_\_ E. Gastro-intestinal Symptoms
  - \_\_\_ \_\_\_ 1. Nausea
  - \_\_\_ \_\_\_ 2. Vomiting
  - \_\_\_ \_\_\_ 3. Abdominal cramps
  - \_\_\_ \_\_\_ 4. Diarrhea
- \_\_\_ \_\_\_ F. Chest symptoms
  - \_\_\_ \_\_\_ 1. Chest pain
  - \_\_\_ \_\_\_ 2. Shortness of breath
  - \_\_\_ \_\_\_ 3. Difficulty breathing

6. List ALL medications you now take including non-prescription drugs (and birth control pills if taken).

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7. Is there anything that you know of that brings on a headache? \_\_\_\_\_

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8. Is there anything that you know of that aggravates a headache? \_\_\_\_\_

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9. Is there anything that makes your headache better? \_\_\_\_\_

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10. Does reading or close work make headaches worse? \_\_\_\_\_

11. Does exertion make headaches worse? \_\_\_\_\_

12. Do you have any of the following diseases?

YES NO

- \_\_\_ \_\_\_ 1. Arthritis
- \_\_\_ \_\_\_ 2. Rheumatic disease
- \_\_\_ \_\_\_ 3. High blood pressure (Hypertension)
- \_\_\_ \_\_\_ 4. Diabetes
- \_\_\_ \_\_\_ 5. Chronic kidney disease
- \_\_\_ \_\_\_ 6. Ulcers of the stomach
- \_\_\_ \_\_\_ 7. Asthma
- \_\_\_ \_\_\_ 8. Hay fever
- \_\_\_ \_\_\_ 9. Food allergies
- \_\_\_ \_\_\_ 10. Chronic constipation

13. Please list all illnesses you have had for the past 3 years. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Do you smoke? \_\_\_\_\_  
What? \_\_\_\_\_  
How many? \_\_\_\_\_

15. Do you use alcohol? \_\_\_\_\_  
How much per day? \_\_\_\_\_  
What form or forms?  
Beer \_\_\_\_\_ Scotch \_\_\_\_\_  
Wine \_\_\_\_\_ Gin \_\_\_\_\_  
Bourbon \_\_\_\_\_ Vodka \_\_\_\_\_  
Other \_\_\_\_\_

16. Does headache ever occur within 30 minutes after use of alcohol? \_\_\_\_\_

YES NO

\_\_\_\_\_ \_\_\_\_\_ 17. Have you ever had a severe head injury?  
When? \_\_\_\_\_  
What? \_\_\_\_\_  
How? \_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ 18. Have you ever had a severe neck injury?  
When? \_\_\_\_\_  
What? \_\_\_\_\_  
How? (Auto accident, sports, fall, etc.) \_\_\_\_\_  
\_\_\_\_\_

19. Do you have:

YES NO

\_\_\_\_\_ \_\_\_\_\_ A. Feelings of tenseness of anxiety with no real cause  
\_\_\_\_\_ \_\_\_\_\_ B. Financial problems  
\_\_\_\_\_ \_\_\_\_\_ C. Marital problems  
\_\_\_\_\_ \_\_\_\_\_ D. Problems with neighbors  
\_\_\_\_\_ \_\_\_\_\_ E. Problems with employer  
\_\_\_\_\_ \_\_\_\_\_ F. Problems with fellow employees  
\_\_\_\_\_ \_\_\_\_\_ G. Problems with children  
\_\_\_\_\_ \_\_\_\_\_ H. Problems with in-laws  
\_\_\_\_\_ \_\_\_\_\_ I. Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# HEADACHE DISABILITY INDEX

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ Scores Total: \_\_\_\_\_; E \_\_\_\_\_; F \_\_\_\_\_  
(100) (52) (48)

**INSTRUCTIONS:** Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than 1 but less than 4 per month [3] more than one per week
2. My headache is: [1] mild [2] moderate [3] severe

**INSTRUCTIONS:** (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off “YES”, “SOMETIMES”, or “NO” to each item. Answer each question as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F2. Because of my headaches I feel restricted in performing my routine daily activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E3. No one understands the effect my headaches have on my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E5. My headaches make me angry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E6. Sometimes I feel that I am going to lose control because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F7. Because of my headaches I am less likely to socialize.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E9. My headaches are so bad that I feel I am going to go insane.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E10. My outlook on the world is affected by my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E11. I am afraid to go outside when I feel that a headache is starting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E12. I feel desperate because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E14. My headaches place stress on my relationships with family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F15. I avoid being around people when I have a headache.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F17. I am unable to think clearly because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F18. I get tense (e.g. muscle tension) because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19. I do not enjoy social gatherings because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E20. I feel irritable because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F21. I avoid traveling because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E22. My headaches make me feel confused.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E23. My headaches make me feel frustrated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F24. I find it difficult to read because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F25. I find it difficult to focus my attention away from my headaches and on other things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital headache disability inventory (HDI). Neurology 1994;44:837-842.