Neurology Associates of Rochester
Follow-up Patient Headache Questionnaire

Name: ______________________________

DOB: ______________________ Today's Date: _________________

In the past 3 months:

How many **total** headaches do you have in a month on average? ______
How long do they last? ______

How many **severe** headaches do you have in a month on average? ________
How long do they last? _____

How many days a month are you **headache FREE**? ___________
What is the longest period you have gone headache free? _________________

How many days a month on average do headaches **limit your ability** to do usual daily activities like work, household work, school or social activities? ___________

Have you been to the ED/urgent care for headache? yes / no

Do you **currently** have a headache? yes / no

When did it start? ____

In the past 3 months, **when you have a headache**, what medications do you take and how many doses do you take to try and relieve the headache (abortive treatment)?
____
____

Where does it hurt (circle all that apply): front back right side left side neck

How would you describe the pain of your most severe headaches? (circle all that apply)

Throbbing Aching Stabbing Pressure-like Dull Sharp

Vise-like Pulsating Electric – like Shock-like Heaviness

On a scale of 1-10 how would you rate your most severe headaches (circle one):

minimal	mild	uncomfortable	moderate	distracting	distressing	intense	debilitating	severe	immobilizing
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**