Headache Patient Information Form

Please fill out the following forms to the best of your ability.

****** ALL INFORMATION WILL BE KEPT CONFIDENTIAL ******

I. PERSONAL INFORMATION

Full Name:_____
first middle last

Date of Birth? _____/_____/_____ Age:_____
Month Day Year

Address:_____
Number Street Apt.# City, State Zip Code

Telephone numbers where we can reach you:

Home: _____ best times to call:_____

Work: _____ best times to call:_____

Other:_____ best times to call:_____

1. What is your marital status?

   a. Single; never married
   b. Married If married, how long have you been married?_____
   c. Divorced
   d. Separated
   e. Widowed
   f. Living with partner

2. How many children do you have?_____
   2a. What are the ages of your children?_____

3. How many people live in your household (counting yourself)?_____

4. What is your ethnic background? (circle one only)

   a. Asian/Oriental
   b. African American
   c. Caucasian/White
   d. Hispanic
   d. Other (specify):_____

5. Where were you born?_____
   5a. If not the U.S., how long have you lived in the U.S.?_____

6. What is your native language? ____English ____Other (specify:_____)

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7. What is your educational background? (circle highest completed)

   a. 8 grades or less
   b. Some high school (did not graduate)
   c. High school graduate/GED
   d. Some college (post high school)
   e. Vocational-technical or associate (2 year) degree (A.A., etc.)
   f. College graduate (B.A., B.S., etc.)
   g. Some post-graduate work
   h. Masters level degree
   i. Doctoral level degree (Ph.D., M.D., etc.), or higher

8. Are you currently employed? Yes No

   8a. If YES, please describe what you do in your job.

   _____

   _____

   8b. If NO, please describe your last job and indicate when it ended.

   _____

   _____

9. What is the estimated total income per year of your household?

   a. Under $10,000 b. $10,000 - $19,000
   c. $20,000 - $29,000 d. $30,000 - $39,000
   e. $40,000 - $49,000 f. $50,000 - $59,000
   g. $60,000 - $69,000 h. $70,000 or more

10. Who referred you to the clinic? If not referred, how did you hear about this clinic?_____

11. Please provide us with the names, addresses and phone numbers of two people who will always know how to reach you (other than your spouse).

    Name #1: _____

    Address: _____

    _____

    Phone(s): _____

    Name #2: _____

    Address: _____

    _____

    Phone(s): _____

PLEASE GO ON TO THE NEXT PAGE

II. MEDICAL HISTORY

1. What was the approximate date of your last physical examination? _____

2. Are you currently under the care of a physician for your headaches? YES NO
   2a. If YES, please list the name, address, and specialty of your doctor:

   _____

   _____

3. What was the approximate date of your last physician or emergency room visit for your headache problems? _____

4. Do you have a physician that you see when you are ill? YES NO
   4a. If YES, please list the name, address, and specialty of your doctor:

   _____

   _____

   4b. If NO, please list the name, address, and specialty of your previous doctor:

   _____

   _____

5a. About how many times have you seen a physician about your headaches in the past six (6) months? (include office visits, emergency room visits, etc.) _____

5b. About how many times have you seen a physician for reasons other than your headaches in the past six (6) months? (include office visits, emergency room visits, etc.) _____

6. Do you now, or have you ever had any of the following disorders?

	No	Yes	Age of Onset	List Family Members Also Diagnosed
Allergies	_____			
Angina (chest pain)	_____			
Arthritis	_____			
Asthma	_____			
Cancer	_____			
Chronic back or neck pain	_____			
Diabetes	_____			
Emotional/nervous disorder	_____			
Encephalitis	_____			
Epilepsy	_____			
Headache (migraine)				
Headache (tension)	_____			
Headache (other)				
Heart trouble				
Hepatitis				
High blood pressure				
Kidney disease	_____			
Liver disease	_____			
Mitral valve prolapse				
Stroke	_____			
Thyroid disorder	_____			
TMJ problems				
Ulcers	_____			
Other	_____			

7. Please list any surgeries you have had and the approximate dates they were done:

_____

_____

8. Have you ever had severe infections of your eyes, ears, or sinuses? YES NO

8a. If YES, please describe and give date of most recent episode: _____

_____

9. Do you have any physical problems or illnesses at this time that seriously affect your health? YES NO

9a. If YES, please explain: _____

_____

10. Do you have any chronic medical conditions or illnesses not yet described? YES NO

10a. If YES, please explain: _____

_____

11. Do you currently have or have you ever had any of the following symptoms?

		YES	NO
a.	sharp pain in jaw caused by movement of jaw or clenching teeth……	____	____
b.	clicking or popping sound in jaw when mouth is open wide……..	____	____
c.	clicking or popping sound in jaw when eating or talking……	____	____
d.	decreased ability to open mouth wide	____	____
e.	soreness or tenderness in jaw (near ears)	____	____
f.	grinding teeth at night (or during the day).....	____	____
g.	waking up in the night feeling out of breath	____	____

12. List all prescription medications you are taking for any reason.

Prescription Medication	Prescribed Dose	Problem Used For

13. List all non-prescription (over-the-counter) medications you are taking for any reason.

Over-the-Counter Medication	Dose Used	Problem Used For

14. Have you ever been under the care of a psychologist, psychiatrist, or other mental health professional? YES NO
    If YES, please indicate:
    - 14a. How long you were, or have you been, in treatment? _____
    - 14b. When you were last treated? _____
    - 14c. What you were treated for? _____
    - 14d. What medications were prescribed? _____

15. What is your current height? _____ 15a. Current Weight? _____

16. What is the most you have weighed in the past 5 years? _____

17. What is the least you have weighed in the past 5 years? _____

18. In the past 6 months have you had any changes in your weight? YES NO
    If YES:
    - 18a. Did you: _____gain weight _____lose weight
    - 18b. When did the changes occur? _____
    - 18c. Why did the changes occur? _____

19. Have you experienced any recent changes in your sleep habits/patterns? YES NO
    If YES:
    - 19a. When did the changes occur? _____
    - 19b. Describe the changes _____
    - 19c. Why did the changes occur? _____

20. In a TYPICAL WEEK, how many days do you drink alcohol? 0 1 2 3 4 5 6 7 days

21. In a TYPICAL WEEK, how many days do you drink caffeinated beverages?
    0 1 2 3 4 5 6 7 days

22. Have you ever smoked cigarettes regularly? YES NO

25. Do you currently smoke cigarettes? YES NO
    If YES, please indicate:
    - 25a. At what age did you begin smoking on a regular, daily basis? _____
    - 25b. How many cigarettes to you smoke in a TYPICAL DAY? _____
    - 25c. Are you interested in quitting smoking? YES NO

PLEASE GO ON TO THE NEXT PAGE

III. HEADACHE HISTORY

1. What level of headache are you experiencing right now? (Circle one)

0	1	2	3	4	5	6	7	8	9	10
No Headache	*	Slightly Painful	*	Mildly Painful	*	Painful	*	Very Painful	*	Extremely Painful

2. Check all headache diagnoses have you received from a physician.

a. _____ Migraine
b. _____ Muscle Contraction or Tension
c. _____ Sinus
d. _____ Mixed or Combined
e. _____ Cluster
f. _____ Vascular
g. _____ Posttraumatic
h. _____ Other, please specify _____

3. Which of the following procedures have ever been used by your physicians to arrive at your headache diagnosis? (check all that apply)

_____	physical exam	_____	neurological exam
_____	EEG	_____	CT or CAT scan
_____	skull x-ray	_____	thermogram
_____	doppler flow study	_____	MRI or NMR tests
_____	blood tests	_____	lumbar puncture/spinal tap
_____	interview only	_____	cerebral angiogram/arteriogram
_____	Other (please describe):	_____	
_____	None		

4. Which of the treatments below have you ever had for treatment of your headache(s)? (circle all that apply and use the following scale to estimate how often you experience adequate relief)

****

1	2	3	4	5	6	7
Never	Rarely	Occas.	Sometimes	Often	Usually	Always

****

	TRIED	RELIEF
a. prescription medication	YES NO	1 2 3 4 5 6 7
b. non-prescription medication	YES NO	1 2 3 4 5 6 7
c. professional massage	YES NO	1 2 3 4 5 6 7
d. chiropractic manipulation	YES NO	1 2 3 4 5 6 7
e. physical therapy	YES NO	1 2 3 4 5 6 7
f. relaxation training	YES NO	1 2 3 4 5 6 7
g. biofeedback	YES NO	1 2 3 4 5 6 7
h. psychotherapy/counseling	YES NO	1 2 3 4 5 6 7
i. allergy shots	YES NO	1 2 3 4 5 6 7
j. hospitalization	YES NO	1 2 3 4 5 6 7
k. dental bite correction	YES NO	1 2 3 4 5 6 7
l. botox injection	YES NO	1 2 3 4 5 6 7
m. Other (please describe):_____		1 2 3 4 5 6 7

5. Are you currently or have you ever taken PRESCRIPTION MEDICATIONS for your headaches? YES NO

If YES: Please indicate which medications you have taken for headache IN THE PAST and which ones you ARE TAKING NOW for headache.

BRAND NAME	(generic name)	Past	Now
DARVOCET-N	(propoxyphene)	____	____
DARVON	(propoxyphene)	____	____
DEMEROL	(meperidine)	____	____
DILAUDID	(hydromorphone)	____	____
DOLOPHINE	(methadone HCL)	____	____
DURAGESIC PATCH	(fentanyl)	____	____
MEPERGAN	(meperidine HCl)	____	____
MORPHINE SULPHATE	(morphine sulphate)	____	____
MS CONTIN	(morphine sulphate)	____	____
NUBAIN	(nalpuphine HCl)	____	____
STADOL	(butorphanol)	____	____
ANEXSIA	(hydrocodone)	____	____
BANCAP	(hydrocodone)	____	____
DARVOCET-N 50 or 100	(propoxyphene)	____	____
DARVON COMPOUND	(propoxyphene)	____	____
EMPIRIN w/ CODEINE	(codeine)	____	____
EMPRACET w/ CODEINE	(codeine)	____	____
HY-PHEN	(hydrocodone)	____	____
LORCET	(propoxyphene HCl)	____	____
LORTAB	(hydrocodone)	____	____
MIDRID	(isometheptine)	____	____
OXYCONTIN	(oxycodone)	____	____
PERCOCET	(oxycodone)	____	____
PERCODAN	(oxycodone)	____	____
PERCOGESIC w/ CODEINE	(codeine)	____	____
SYNALGOS	(dihydrocodeine)	____	____
TALWIN COMPOUND	(pentazocine)	____	____
TYLENOL w/ CODEINE	(codeine)	____	____
TYLOX	(oxycodone)	____	____
VICODIN	(hydrocodone)	____	____
WYGESIC	(propoxyphene)	____	____
XYLOCAINE	(lidocaine IN)	____	____
ANAPROX	(naproxen sodium)	____	____
ANSAID	(flurbiprofen)	____	____
CATAFLEM	(diclofenac)	____	____
CELEBREX	(celecobix)	____	____
CLINORIL	(sulindac)	____	____
DOLOBID	(diflunisal)	____	____
EASPRIN	(salicylic acid	____	____
FELDENE	(piroxicam SL)	____	____
INDOBUFEN	(indobufen)	____	____
INDOMETHACIN	(indomethacin)	____	____
KETOROLAC	(toradol)	____	____
LODINE	(etodolac)	____	____
MECLOMEN	(meclofenamate)	____	____
MOTRIN	(ibuprofen)	____	____
NALFON	(fenoprofen)	____	____
NAPROSYN	(naproxen sodium)	____	____
ORUDIS	(ketoprofen)	____	____
PONSTEL	(mefenamic acid)	____	____

BRAND NAME	(generic name)	Past	Now
TOLECTIN	(tolmetin)	____	____
TOLFENOMIC ACID	(tolfenomic acid)	____	____
TORADOL	(ketorolac)	____	____
TRILISATE	(salicylic acid)	____	____
VIOXX	(rofecoxib)	____	____
VOLTARIN	(diclofenac sodium)	____	____
XEFO	(lornoxicam)	____	____
BELLERGAL-S	(ergotamine)	____	____
CAFERGOT PB	(ergotamine)	____	____
CAFERGOT	(ergotamine)	____	____
D.H.E. 45	(dihydroergotamine)	____	____
ERGOMAR	(ergotamine)	____	____
ERGOSTAT	(ergotamine)	____	____
METHERGINE	(methylergonovine)	____	____
SANSERT	(methysergide)	____	____
TR-DHE	(dihydroergotamine)	____	____
UTERGIN	(methylergometrine)	____	____
WIGRAINE	(ergotamine)	____	____
AMERGE	(naratriptan)	____	____
FROVA	(frovatriptan)	____	____
IMIGRAN	(sumatriptan)	____	____
IMITREX	(sumatriptan)	____	____
MAXALT	(rizatriptan)	____	____
RELPAX	(eletriptan)	____	____
TRIPT-OH	(oxytryptan)	____	____
ZOMIG	(zolmitriptan)	____	____
FLEXERIL	(cyclobenzaprine)	____	____
NORFLEX	(orphenadrine)	____	____
NORGESIC	(orphenadrine)	____	____
PARAFLEX	(chlorzoxazone)	____	____
PARAFON FORTE	(chlorzoxazone)	____	____
ROBAXIN	(methocarbamol)	____	____
SOMA COMPOUND	(carisoprodol)	____	____
SOMA COMPOUND w/codeine	(carisoprodol)	____	____
APTIN	(alprenolol)	____	____
BLOCKADREN	(timolol)	____	____
CORGARD	(nadolol)	____	____
INDERAL	(propranolol)	____	____
INDERIDE	(propranolol)	____	____
LOPRESSOR	(metoprolol)	____	____
OXYPRENOLOL	(oxyprenolol)	____	____
PRACTOLOL	(practolol)	____	____
SECTRAL	(acebutolol)	____	____
TENORMIN	(atenolol)	____	____
VISKEN	(pindolol)	____	____
ZEBETA	(bisoprolol)	____	____

5. (continued)

Please indicate which medications you have taken for headache IN THE PAST and which ones you ARE TAKING NOW for headache.

BRAND NAME	(generic name)	Past	Now
CATAPRES	(clonidine)	____	____
TENEX	(guanfacine)	____	____
ADALAT	(nifedipine)	____	____
CALAN	(verapamil HCl)	____	____
CARDENE	(nicardipine)	____	____
CARDIZEM	(diltiazem)	____	____
CYCLOSPASMOL	(cycandelate)	____	____
ISOPTIN	(verapamil)	____	____
NIMOTOP	(nimodipine)	____	____
PROCARDIA	(nifedipine)	____	____
SIBELIUM	(funarizine)	____	____
CELEXA	(citalopram)	____	____
FEMOXETINE	(femoxetine)	____	____
LUVOX	(fluvoxamine)	____	____
MIANSERIN	(mianserin)	____	____
OPRIMOL	(opipramol)	____	____
PAXIL	(paroxetine)	____	____
PROZAC	(fluoxetine)	____	____
SERZONE	(nefazedone)	____	____
ZOLOFT	(sertraline)	____	____
ADAPIN	(doxepin)	____	____
ANAFRANIL	(clomipramine)	____	____
ASENDIN	(amoxapine)	____	____
DESYREL	(trazadone)	____	____
EFFEXOR	(ventafazine HCl)	____	____
ELAVIL	(amitriptyline)	____	____
ENDEP	(amitriptyline)	____	____
LIMBITROL	(amitriptyline)	____	____
NARDIL	(phenelzine)	____	____
NORPRAMINE	(desipramine)	____	____
PAMELOR	(nortriptyline)	____	____
REMERON	(mirtazepine)	____	____
SINEQUAN	(doxepin)	____	____
TOFRANIL	(imipramine)	____	____
VIVACTIL	(protriptyline)	____	____
WELLBUTRIN	(bupropion HCl)	____	____
ESKALITH	(lithium carbonate)	____	____
LITHOBID	(lithium carbonate)	____	____
VISTARIL	(hydroxyzine HCl)	____	____
DILANTIN	(phentoin sodium)	____	____
TEGRETAL	(carbamazepine)	____	____
DEPAKOTE	(divalproex sodium)	____	____
DEPAKENE	(sodium valproate)	____	____
NEURONTIN	(gabapentin)	____	____
GABITRIL	(tiagabine)	____	____
TOPAMAX	(topiramate)	____	____
TRILEPTAL	(oxcarbazepine)	____	____

BRAND NAME	(generic name)	Past	Now
KLONOPIN	(clonazepam)	____	____
LIBRAX	(chlordiazepoxide)	____	____
LIBRIUM	(chloradiazepoxide)	____	____
TRANXENE	(clorazepate)	____	____
VALIUM	(diazepam)	____	____
XANAX	(alprazolam)	____	____
RESTORIL	(temazepam)	____	____
REGLAN	(metoclopramide)	____	____
THORAZINE	(chlorpromazine)	____	____
COMPAZINE	(prochloraperazine)	____	____
HALDOL	(haloperidol)	____	____
TIGAN	(trimethobenzamide)	____	____
PHENERGAN	(promethazine)	____	____
AXOTAL	(butalbital)	____	____
ESGIC	(butalbital)	____	____
FIORICET	(butalbital)	____	____
FIORICET w/ codeine	(butalbital)	____	____
FIORINAL	(butalbital)	____	____
FIORINAL w/ codeine	(butalbital)	____	____
PHRENALIN	(butalbital)	____	____
TRIAD	(butalbital)	____	____
PERIACTIN	(cyproheptadine)	____	____
SANDOMIGRAN	(pizotifen)	____	____
DOPERGIN	(lisuride)	____	____
IPRAZOCHROME	(iprazochrome)	____	____
NAVOBAN	(tropisetron)	____	____
EQUAGESIC	(meprobamate)	____	____
ESTRACE	(estradiol)	____	____
FEVERFEW	(tanacetum parthenium)	____	____
MAGNACAPS	(magnesium)	____	____
MAG-OX 400	(magnesium)	____	____
MIDRIN	(isometheptine)	____	____
MIGRALAM	(isometheptine)	____	____
PREMARIN	(estradiol)	____	____
VITAMIN B2	(riboflavin)	____	____
other: _____		____	____
other: _____		____	____
other: _____		____	____
other: _____		____	____
other: _____		____	____

6. On the average, how many headache-free days do you have per week?_____

7. On the average, how many days per month do you have a headache? _____

8. On the average, how many hours per day do your headaches last? _____

9. How long have you been having problem headaches? (years, months) _____

Use the following *Headache Intensity Scale* to answer the next three questions:

****

0	1	2	3	4	5	6	7	8	9	10
No Headache	*	Slightly Painful	*	Mildly Painful	*	Painful	*	Very Painful	*	Extremely Painful

****

(0) No Headache
(1)
(2) Slightly Painful -- I only notice my headache when I focus my attention on it.
(3)
(4) Mildly Painful -- I can ignore my headache most of the time.
(5)
(6) Painful -- My headache is painful, but I can continue what I am doing.
(7)
(8) Very Painful -- My headache makes concentration difficult, but I can perform undemanding tasks.
(9)
(10) Extremely Painful - My headache is so painful I can't do anything.

10. What is the average intensity of your headache during a typical headache day?

0 1 2 3 4 5 6 7 8 9 10

11. What is the highest intensity your headache reaches in a typical week?

0 1 2 3 4 5 6 7 8 9 10

12. On average, how intense have your headaches been in the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

13. On average, how intense have your headaches been in the last 30 days?

0 1 2 3 4 5 6 7 8 9 10

IV. GLOBAL MEASURES

Use the following scale to answer questions 1 & 2:

0	1	2	3	4	5	6	7	8	9	10
No Impairment	*	Minimally Impaired	*	Mildly Impaired	*	Moderately Impaired	*	Severely Impaired	*	Completely Impaired

1. On average, how disabled have you been in the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

2. On average, how disabled have you been in the last 30 days?

0 1 2 3 4 5 6 7 8 9 10

Use the following scale to answer questions 3 & 4:

0	1	2	3	4	5	6	7	8	9	10
No Stress	*	Slightly Stressed	*	Mildly Stressed	*	Moderately Stressed	*	Very Stressed	*	Extremely Stressed

3. On average, how stressed have you been in the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

4. On average, how stressed have you been in the last 30 days?

0 1 2 3 4 5 6 7 8 9 10

Use the following scale to answer questions 5 & 6:

0	1	2	3	4	5	6	7	8	9	10
Too Little	*	*	*	*	Perfect	*	*	*	*	Too Much

5. On average, how much sleep have you been getting in the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

6. On average, how much sleep have you been getting in the last 30 days?

0 1 2 3 4 5 6 7 8 9 10

Use the following scale to answer questions 7 & 8:

0	1	2	3	4	5	6	7	8	9	10
Very Poor	*	Poor	*	Fair	*	Good	*	Very Good	*	Excellent

7. On average, what has your sleep quality been in the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

8. On average, what has your sleep quality been in the last 30 days?

0 1 2 3 4 5 6 7 8 9 10

PLEASE GO ON TO THE NEXT PAGE

V. HEADACHE TRIGGER QUESTIONNAIRE

never or almost never	a few times per year	less than 1 time per month	1 to 3 times per month	1 or 2 times per week	3 times per week or more	nearly every day or daily
0	**1**	**2**	**3**	**4**	**5**	**6**

For each item below, please circle **YES** if you believe it can *sometimes* trigger a headache for you, **NO** if you believe it is unlikely to trigger a headache, and **UNSURE** if you are not sure if it can trigger a headache.

FOOD/BEVERAGES: Using the 0 to 6 scale above, please indicate how often you typically consume the following foods and beverages. Then circle *Yes*, *No*, or *Unsure* for each item.

	How Often	Headache Trigger
1. Red wine	0 1 2 3 4 5 6	Yes No Unsure
2. Other alcoholic beverages	0 1 2 3 4 5 6	Yes No Unsure
3. Aged cheese (cheddar, blue cheese)	0 1 2 3 4 5 6	Yes No Unsure
4. Foods with MSG (Chinese food, 'Accent')	0 1 2 3 4 5 6	Yes No Unsure
5. Chocolate	0 1 2 3 4 5 6	Yes No Unsure
6. Caffeinated beverages	0 1 2 3 4 5 6	Yes No Unsure
7. Nuts or peanut butter	0 1 2 3 4 5 6	Yes No Unsure
8. Cured or processed meats (hot dogs, bacon, sausage)	0 1 2 3 4 5 6	Yes No Unsure

BEHAVIOR PATTERNS: Using the 0 to 6 scale above, please indicate how often you engage in the following behavior. Then circle *Yes*, *No*, or *Unsure* for each item.

	How Often	Headache Trigger
9. Eating less food while dieting	0 1 2 3 4 5 6	Yes No Unsure
10. Delaying a meal	0 1 2 3 4 5 6	Yes No Unsure
11. Skipping a meal	0 1 2 3 4 5 6	Yes No Unsure
12. Snacking instead of having a meal	0 1 2 3 4 5 6	Yes No Unsure
13. Sleeping or napping *more* than usual	0 1 2 3 4 5 6	Yes No Unsure
14. Sleeping or napping *less* than usual	0 1 2 3 4 5 6	Yes No Unsure
15. Having insomnia or other sleep disturbances	0 1 2 3 4 5 6	Yes No Unsure
16. Physically exercising to exhaustion	0 1 2 3 4 5 6	Yes No Unsure
17. Feeling overly fatigued	0 1 2 3 4 5 6	Yes No Unsure

MOOD STATES: Using the 0 to 6 scale above, please indicate how often you experience the following mood states. Then circle *Yes*, *No*, or *Unsure* for each item.

	How Often	**Headache Trigger
18. Feeling *moderately* pressured or stressed	0 1 2 3 4 5 6	Yes No Unsure
19. Feeling *very* pressured or stressed	0 1 2 3 4 5 6	Yes No Unsure
20. Feeling *moderately* upset or unhappy	0 1 2 3 4 5 6	Yes No Unsure
21. Feeling *very* upset or unhappy	0 1 2 3 4 5 6	Yes No Unsure
22. Feeling *moderately* irritable or angry	0 1 2 3 4 5 6	Yes No Unsure
23. Feeling *very* irritable or angry	0 1 2 3 4 5 6	Yes No Unsure
24. Feeling *moderately* tense or anxious	0 1 2 3 4 5 6	Yes No Unsure
25. Feeling *very* tense or anxious	0 1 2 3 4 5 6	Yes No Unsure

** Remember, a headache can be triggered either *during* the mood state or within a day or so *after* the mood state has passed (i.e., a "let down headache").

Headache Trigger Questionnaire (page 2 of 2)

ENVIRONMENTAL FACTORS: Please circle *Yes*, *No*, or *Unsure* for each item.

1. Odors ..... Yes No Unsure
2. Smoke ..... Yes No Unsure
3. Chemical vapors ..... Yes No Unsure
4. Strong perfumes or colognes ..... Yes No Unsure
5. Bright light ..... Yes No Unsure
6. Flickering light ..... Yes No Unsure
7. Glare ..... Yes No Unsure
8. Hot environment ..... Yes No Unsure
9. Cold environment ..... Yes No Unsure
10. Loud noise ..... Yes No Unsure
11. Weather or barometric pressure changes ..... Yes No Unsure

FOR WOMEN ONLY: Do you have menstrual periods? **YES NO**
If *Yes*, are you likely to experience more headaches or more severe headaches during any of the following times?

1. Just before menstruation begins ..... Yes No Unsure
2. During menstruation ..... Yes No Unsure
3. Just after menstruation ceases ..... Yes No Unsure
4. Mid-cycle (about the time of ovulation) ..... Yes No Unsure

PLEASE GO ON TO THE NEXT PAGE

VI. HAB

Use the following scale to estimate how much of the time you do each of the following when you have a headache:

1	2	3	4	5	6	7
Never	Rarely	Occas.	Sometimes	Often	Usually	Always

1 2 3 4 5 6 7 1. Take time off work, housework, etc.
1 2 3 4 5 6 7 2. Avoid or minimize physical exertions/activity.
1 2 3 4 5 6 7 3. Avoid or reduce bright lights.
1 2 3 4 5 6 7 4. Avoid or reduce loud noise.
1 2 3 4 5 6 7 5. Avoid or reduce social contacts.

1 2 3 4 5 6 7 6. Go to see a physician.
1 2 3 4 5 6 7 7. Go to the emergency room.
1 2 3 4 5 6 7 8. Try to focus on something other than the headache.
1 2 3 4 5 6 7 9. Take medication.
1 2 3 4 5 6 7 10. Close your eyes.

1 2 3 4 5 6 7 11. Lie down and rest.
1 2 3 4 5 6 7 12. Relax.
1 2 3 4 5 6 7 13. Sleep.
1 2 3 4 5 6 7 14. Tell someone that you have a headache.
1 2 3 4 5 6 7 15. Slump, slouch, or find it hard to stand up.

1 2 3 4 5 6 7 16. Hold or press your head, neck, or temples.
1 2 3 4 5 6 7 17. Use massage, cold compress, etc. to reduce pain.
1 2 3 4 5 6 7 18. Show that it hurts by expression (grimace, squint, frown)
1 2 3 4 5 6 7 19. Show that it hurts through sound (moan, cry out , sigh, etc.)
1 2 3 4 5 6 7 20. Go on with usual activities despite the headache.

Using the same scale, indicate how much of the time your family, friends, or co-workers do each of the following when they know that you have a headache:

1 2 3 4 5 6 7 1. Express concern.
1 2 3 4 5 6 7 2. Do things for you.
1 2 3 4 5 6 7 3. Avoid you.
1 2 3 4 5 6 7 4. Ignore you.
1 2 3 4 5 6 7 5. Offer help.
1 2 3 4 5 6 7 6. Get angry at you.
1 2 3 4 5 6 7 7. Get angry at the situation (the headache).
1 2 3 4 5 6 7 8. Other (describe) _____
1 2 3 4 5 6 7 9. _____
1 2 3 4 5 6 7 10. _____

PLEASE GO ON TO THE NEXT PAGE

VII. WOMEN ONLY

******* THIS SECTION TO BE COMPLETED BY WOMEN ONLY *******

1. How old were you when you began menstruating? _____

2. Are you pregnant at the present time? YES NO

3. Have you ever been pregnant? YES NO

   3a. If YES, did your headaches change during pregnancy? (check only one)

   Headaches were not a problem for me at that time ..... _____
   Yes, the headaches disappeared completely..... ..... _____
   Yes, the headaches improved somewhat .... _____
   No, the headaches were not affected by the pregnancy ..... _____
   Yes, the headaches got somewhat worse .... _____
   Yes, the headaches became much more intense .... _____

4. Are you currently or have you ever taken oral contraceptives (birth control pills), depo-provera (shot), Norplant? YES NO
   If YES, what type do/did you take?_____

   4a. If YES, how long did you take them? _____ years _____ months

   4b. Did oral contraceptives change your headaches in any way? (check one)
   Headaches were not a problem for me at that time . ..... …… _____
   Yes, my headaches disappeared completely..... ....____
   Yes, my headaches improved somewhat .... …… _____
   No, my headaches were not affected ....____
   Yes, my headaches got somewhat worse.... .... …… _____
   Yes, my headaches became much more intense .... …… _____

   4c. Are you still taking oral contraceptives? YES NO
   If NO, When did you stop? _____
   Why did you stop? _____

5. Have you ever used female hormone supplements (e.g., Premarin tablets or vaginal creams, estrone, or estrogens)? YES NO

   If YES, please answer the following:

   5a. How long did you take them? _____ years _____ months

   5b. Did the hormone supplements change your headaches : (check one)

   Headaches were not a problem for me at that time . ..... …… _____
   Yes, my headaches disappeared completely..... ....____
   Yes, my headaches improved somewhat..... .... …… _____
   No, my headaches were not affected ....____
   Yes, my headaches got somewhat worse.... .... …… _____
   Yes, my headaches became much more intense .... …… _____

   5c. Are you currently taking the hormone supplements? YES NO
   If No: When did you stop? _____
   Why did you stop? _____

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6. About when did you last have a gynecological or pelvic exam? _____

7. About how often do you see a gynecologist? _____

8. Have you ever experienced any of the following:

YES NO Menstrual periods stopped for 12 months or more
YES NO Hot flashes (flushes)
YES NO Irregular menstrual periods
YES NO Fertility problems
YES NO Hormone imbalance
YES NO Endometriosis
YES NO Excessive, very heavy menstrual bleeding
YES NO Pelvic inflammatory disease
YES NO Ovarian cysts
YES NO Severe pain with menstruation over at least 6 cycles which prevented you from going to work or school
YES NO Other menstrual problems (please specify): _____
_____
YES NO Other gynecological problems (please specify): _____
_____

9. Do you still have menstrual periods? YES NO

If YES, Answer questions 10-13, Skip questions 14-16.
If NO, Skip question 10-13 and Answer questions 14-16.

10. Can you usually predict when your period will begin by looking at a calendar? YES NO

11. How many days do your cycles usually last (from the start of one period to the start of the next period) ? _____

12. If you have unusual or extreme symptoms associated with your periods, please describe them:

_____

_____

13. Have you noticed any relationship between your migraines and your menstrual cycle? If YES please describe in terms of proximity of migraine to menstrual cycle phases:

_____

_____

14. How much do the number of days in your cycle vary from month to month?
_____ 0-2 days
_____ 3-4 days
_____ 5-7 days
_____ More than 7 days

15. How many days does the menstruation portion of your cycle usually last? _____

16. How many times have you been pregnant, if ever? _____

17. Have you ever experienced a miscarriage? Yes _____ No _____

IF YOU HAVE NOT HAD MENSTRUAL PERIODS IN THE PAST 12 MONTHS,
PLEASE ANSWER 18-20:

18. What was the approximate date of your last menstrual period? _____

19. Have your periods stopped due to :
_____ menopause (change of life)
_____ hysterectomy
_____ illness (please specify illness): _____
_____ other (please specify reason): _____

20. Have you had a hysterectomy? YES NO
If YES,
15a. When did you have the surgery? _____
15b. What was the reason for the surgery? _____
15c. Were your ovaries removed? ____ No
____ One ovary removed
____ Two ovaries removed
____ Don't know