Date: .....

1. Patient history

Last name:.....

First name:.....

Date of birth (dd-mm-yy) .....

Mobile phone number:.....

E-mail*:*

General practitioner:.....

Referred by:.....

2. Headache history

-Do you have more than 1 headache type?

☐ No

☐ Yes: Describe briefly the different headaches here. **If necessary complete on page 11**

……..

……..

.....

.....

.....

Please continue describing the most important headache.

a) Are you ever headache free?

☐ No

☐ Yes. When, in which period?

☐ Pregnancy

☐ Vacation

☐ Weekends

☐ Random

☐ Other: .....

.....

b) Onset of first headache:

Started…….ago. I was……years old.

c) What provoked your first headache?:

☐ I don't know.

☐ First menstrual period.

☐ Pregnancy.....

☐ Hormonal treatment

☐ Pre-menopause/ menopause

☐ Other.....

.....

☐ Injury/accident:.....

.....

d) Current pattern (how fast):

☐ Sudden ☐ Rapid ☐ Gradual ☐ Varies

Moment of the day::

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Awakens from sleep ☐ Varies

When is the headache more frequent:

☐ Weekends ☐ Weekdays ☐ Vacations
☐ Spring ☐ Summer ☐ Fall ☐ Winter

e) Frequency (number of attacks):

…….. # day …… # week ……. # month …… # year …….. # in life …….. continuous

f) Duration:

Lasts .....minutes ..... hours .....days. WITH medication
How many remissions within 24h? .....

Lasts .....minutes ..... hours .....days WITHOUT medication
How many remissions within 24h? .....

g) Severity. How bad is the pain on a scale of 0 to 10?
Highest level:..... Lowest level:.....
Average level: .....
Worse with menses? ☐ Yes ☐ No

h) Location:

☐ Temples ☐ Back of head ☐ Side of head ☐ Neck ☐ Around head
☐ Eye ☐ Ear ☐ Front of head ☐ Jaw ☐ Other:

Which side?

☐ Right-sided
☐ Left-sided
☐ Both sides
☐ Varies

Change sides

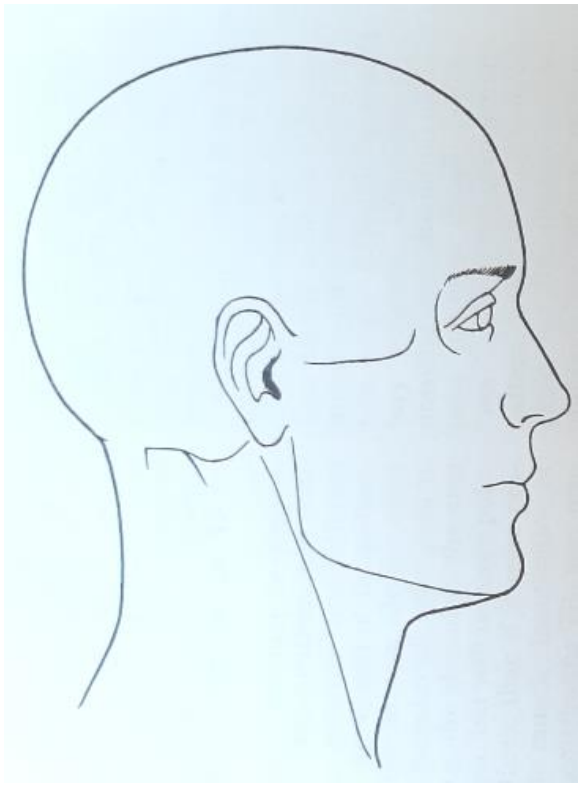
☐ Between attacks
☐ During attacks
☐ Both between and during

Character:

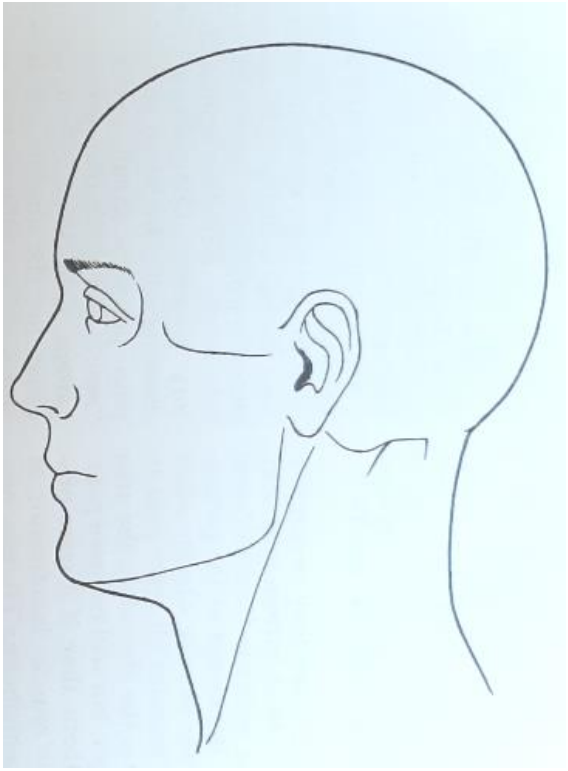
☐ Throbbing/pulsing
☐ Achy
☐ Tight
☐ Dull
☐ Stabbing
☐ Pressure
☐ Burning
☐ Searing
☐ Shooting
☐ Other:.....

i) **Where does the pain start (indicate with 1) and how does the pain radiate (indicate with 2, 3, 4…).**

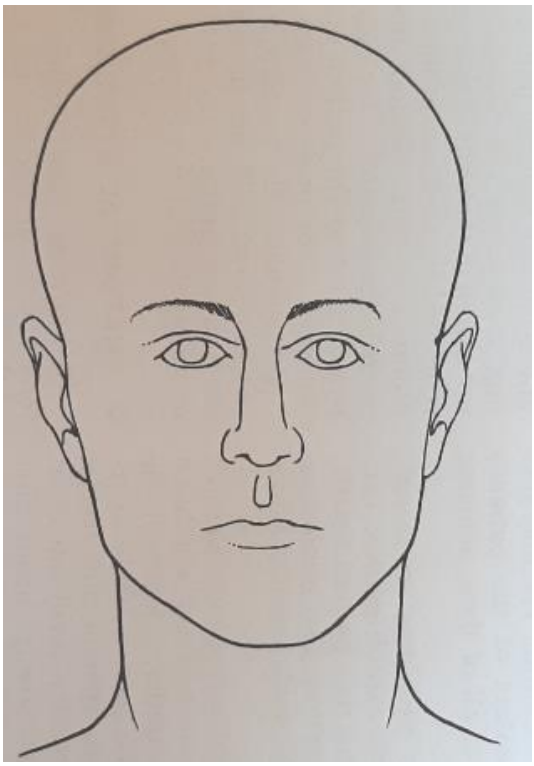
RIGHT



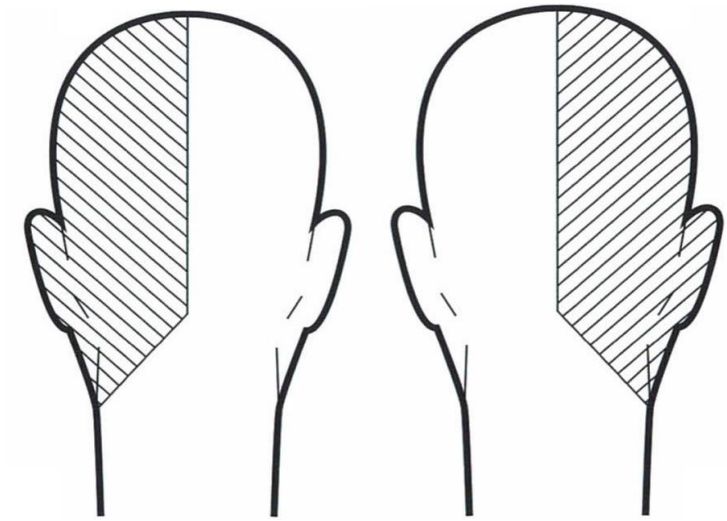
LEFT



FOREHEAD/ FACE:



BACK of HEAD/ NECK:



see also pages 9-11.

j) Activity that worsens your headache.

☐ None
☐ Climbing steps
☐ Other: .....
☐ Walking
☐ Exercise

Headache disability during of after an attack:

☐ Normal
☐ Moderate decrease in function
☐ Confined to bed
☐ Slight decrease in function
☐ Severe decrease in function

k) Additional complaints:

☐ Nausea	☐ Sore/stiff neck	☐ Blurred vision
☐ Vomiting	☐ Anxiety	☐ Drooping eyelid (Rt-Lt)
☐ Sensitive to light	☐ Concentration problems	☐ Eye-tearing (Rt-Lt)
☐ Sensitive to sounds	☐ Memory problems	☐ Eye- redness (Rt-Lt)
☐ Sensitive to odours	☐ Ringing in the ears	☐ Change in pupil
☐ Diarrhea	☐ Pressure in ears (Rt-Lt)	Larger- Smaller
☐ Confusion	☐ Increased urination	☐ Dripping nose
☐ Other:	.....	☐ Nose congested (Rt-Lt)

l) Aura : (symptoms before headache begins or at the beginning)

Visual aura

☐ Blurry vision	☐ Loss of vision in one eye	☐ Tunnel vision
☐ Flashing lights	☐ Loss of vision on one side	☐ Double vision
☐ Zigzag lines	☐ Total blindness	☐ Other:

Do the symptoms spread?

☐ Yes, spreads slowly
☐ No, begins all at once

Visual symptoms

☐ start before headache pain
☐ start during headache pain (same time)
☐ start both before and during
☐ last a total of.....

How long does the aura last before head pain starts?.....
How long does the aura and the headache last together? .....
If you have more than one symptom, do they happen all at once?

☐ Yes ☐No, one by one

Do you have visual aura without headache pain? ☐ Yes ☐ No

Aura- sensory.

Numbness/tingling:
☐ Right
☐ Left
☐ Both

☐ Dizziness/unsteadiness
☐ Vertigo[1]
☐ Light headedness
☐ One-sided weakness

☐ General weakness
☐ Speech difficulty
☐ Unable to speek
☐ Other: .....

Do the symptoms spread?
☐ Yes, spreads slowly
☐ No, begins all at once

Sensory symptoms
☐ start before headache pain
☐ start during headache pain (same time)
☐ start both before and during
☐ last a total of.....

How long does the sensory aura last before head pain starts? .....
How long does the aura and the headache last together? .....

If you have more than one symptom, do they happen all at once?
☐ Yes ☐No, one by one

Do you have sensory aura without headache pain? ☐ Yes ☐ No

m) Premonitory symptoms
Do you experience one or more of these symptoms the day before or hours before onset of headache?

☐ Heightened feeling of wellness
☐ Hyperactive
☐ Extremely talkactive
☐ Depressed feeling
☐ Irritability
☐ Feeling sluggish
☐ Drowsy
☐ Restless
☐ Dizziness[2]

☐ Difficulty concentrating
☐ Sensitive to light
☐ Sensitive to sound/noise
☐ Sensitive to odors
☐ Difficulty with speech
☐ Excessive yawning
☐ Neck stiffness
☐ Craving for food
☐ Weakness

☐ Increased appetite
☐ Decreased appetite
☐ Feeling cold
☐ Diarrhea
☐ Constipation
☐ Extremely thristy
☐ Increased urination
☐ Fluid retention
☐ Other:.....

n) Provoking factors. Things that can cause a headache

<u>Food/beverage:</u>

☐ Missing a meal ☐ Chocolate ☐ Coffeine ☐ Nitrates ☐ Mono-NaGlu
☐ Alcohol ☐ Red wine ☐ White wine ☐ Missing a meal ☐ Other:

<u>Physical exertion:</u>

☐ Coughing ☐ Straining to defecate ☐ Chewing ☐ Exercise ☐ Sexual intercourse

---

[1]

[2] **If you frequently suffer from vertigo/ dizziness, please complete the questionnaire dizziness. You can find this document on my website http://www.dr-paul-louis.be/en/questionnaires/ .**

Hormonal

Menses: ☐ before ☐ during ☐ after
☐ Pregnancy ☐ Menopause

Stress

☐ Work ☐ Home ☐ Family ☐ Spouse ☐ Other:

Environnemental

☐ Allergies ☐ Weather changes ☐ Altitude ☐ Sunlight ☐ Other:

Sleep

☐ Lack of sleep ☐ Too much sleep ☐ Change in wake/sleep

Other:

.....
.....

o) Relieving factors

☐ Lying down ☐ Dark quiet room ☐ Massage
☐ Hot compress ☐ Cold compress ☐ Pregnancy
☐ Keeping active ☐ Standing ☐ Other:

3. Quality of life:

My appetite lately is: ☐ increased ☐ decreased ☐ not changed
My mood lately is: ☐ better ☐ worse ☐ not changed

My psychical condition can be described as:
☐ anxious ☐ calm ☐ euphoric
☐ irritable ☐ depressed

I get ..... hours of sleep per night.
Difficulties falling asleep : ☐ Yes ☐ No
I wake up during the night or early morning due to my headache:
☐ Yes ☐ No
I wake up with headache: ☐ Yes ☐ No
Sexual difficulties: ☐ Yes ☐ No

Effect of headache on daily life:
☐ work activity.....# days per month missed.
☐ absence of school.....# days per month missed.
☐ Social, familial activities..... # days per month missed.

4. Current treatment

- For headache (incl. painkillers + number per day or per week):

.....
.....
.....
.....

- In general (medication not for headache):

.....
.....
.....
.....

- Current contraception:

.....

5. Previous Treatments and testing.

a) Previous treatments:

☐ General practitioner: .....
☐ Specialist nose-throat-ear:.....
☐ Dentist: .....
☐ Chiropractor:.....
☐ Fysio-kine: .....
☐ Alternative treatments:.....
.....

b) Previous tests:

☐ MRI head.....
☐ MRA-MRV .....
☐ Cervical MRI.....
☐ CT head.....

c) Medications, already taken:

- For headache **(preventive)**:

Name of the medication (preventive)	**Dose**	**For how long?**	**Side effects**
Example: Propranolol	*80 mg/day*	*3 months*	*Dizziness*

- For the **attack:**

Name of the medication (for the attack)	**Dose**	**How much on average?**	**Side effects**
Example: Sumatriptan	*50 mg*	*8 per month*	*Heart palpitations*

- In general (medication <u>not</u> for headache):

.....
.....
.....
.....

- Contraception (in the past):

.....
.....

6. <u>Antecedents</u>

a) Personal antecedents (beside headache):

.....
.....
.....

b) Familial antecedents:

- Relatives with headache:.....
  .....
  .....
  .....
- Important medical antecedents of relatives:.....
  .....
  .....
  .....

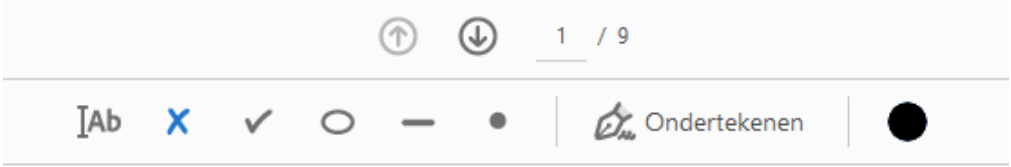
7. Social life and lifestyle

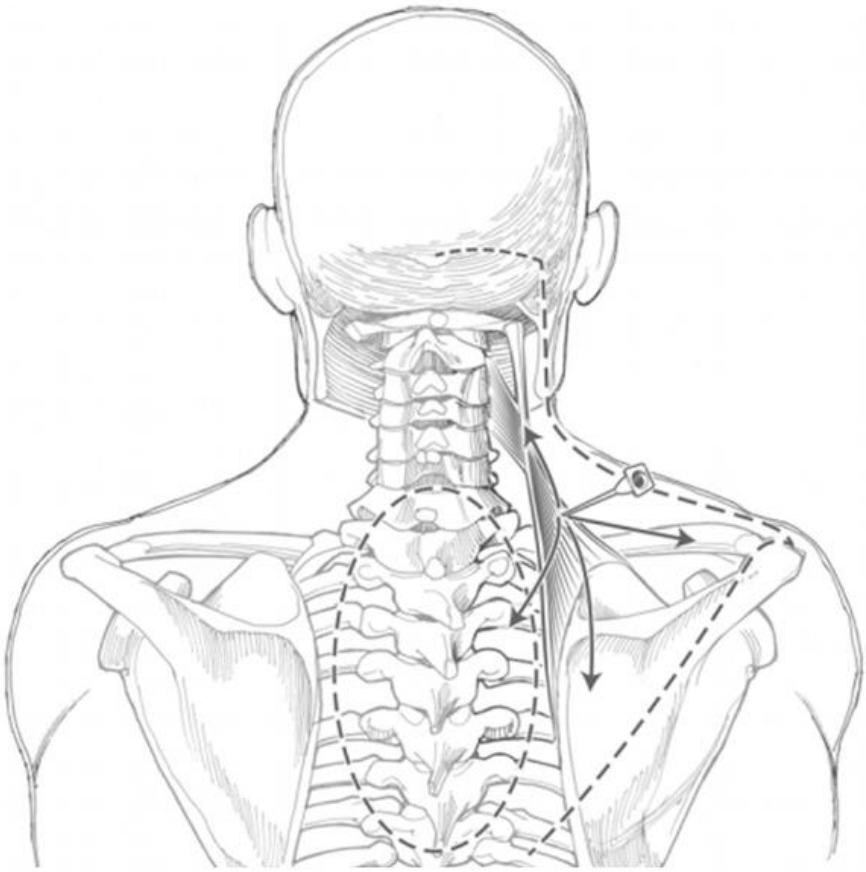
I live in a household of ..... people and I have..... children.
Education:.....
Type of work: .....

I drink..... # cups of coffee a day.
I drink..... # alcoholic beverages
☐ per day ☐ per week ☐ per month

I smoke..... # cigarettes per day.
I practice a sport: ☐ No ☐ Yes, …… times per week
Weight:…….. kg, length:……..cm.
Blood pressure: ..... mmHg

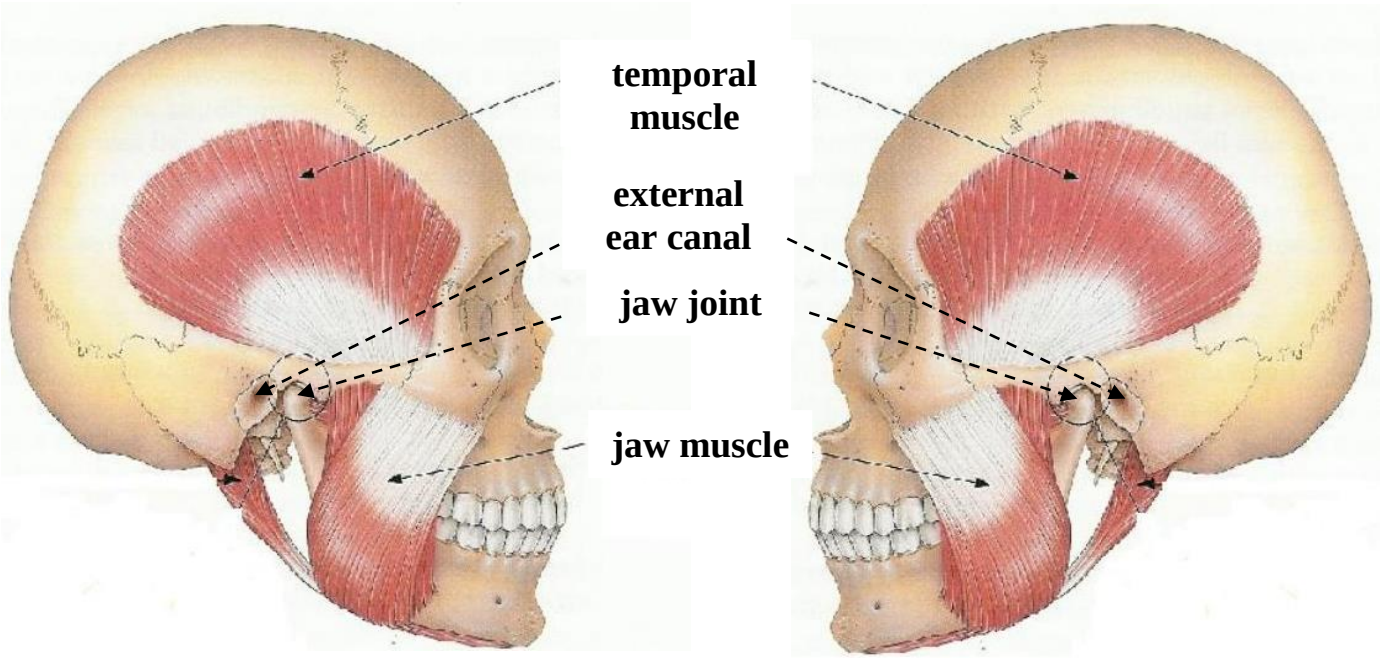
When you have **neck pain[3] radiating to the back of your head and shoulders**, indicate the starting point of the pain and where the pain radiates. Select a line in the Adobe Acrobat Reader program and trace the line from the starting point.



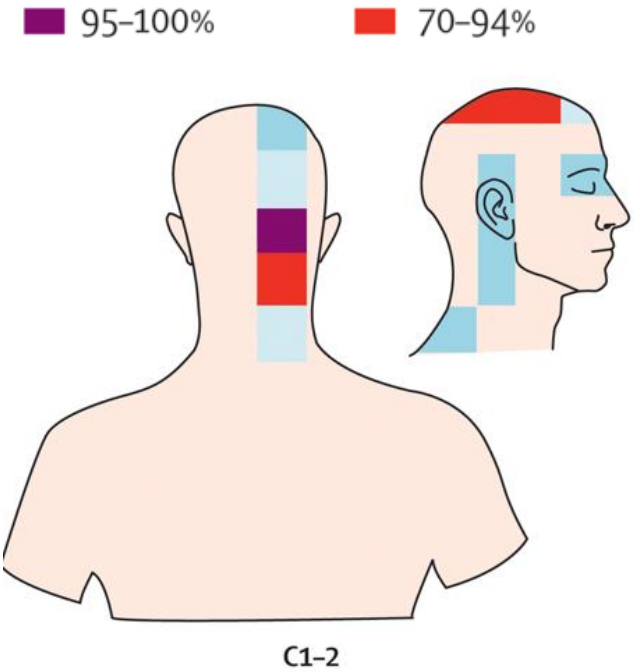


[3] **If you frequently suffer from neck pain, please also complete the questionnaire for neck pain, which you can find on http://www.dr-paul-louis.be/en/questionnaires/ .**

When you have **jaw pain**, indicate the starting point of the pain and where the pain radiates. Select a line in the Adobe Acrobat Reader program and trace the line from the starting point.



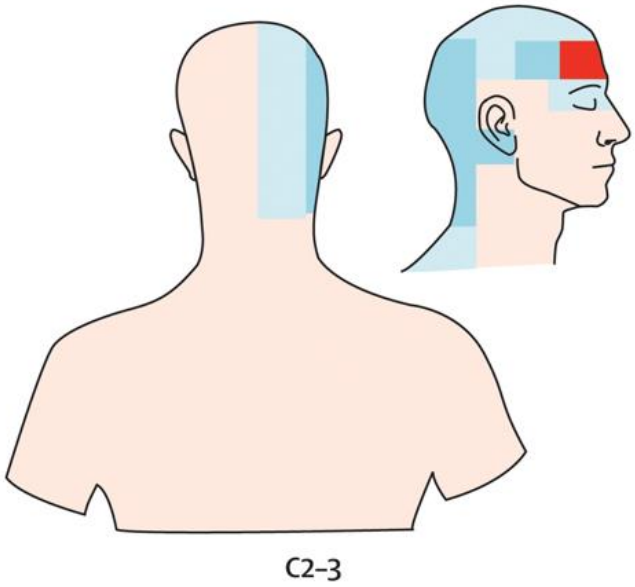
When you **have pain at the back of your head that radiates to the top of the head, the temporal region, the front and to a lesser degree to the shoulders**, select one of the 3 images. Read the description and make a choice.



The pain predominates between thee ears on one side only (right OR left and on the top of the head).

☐ Check the box if C1-C2 fits your pain best.

95–100% 70–94% 45–69% 20–44%

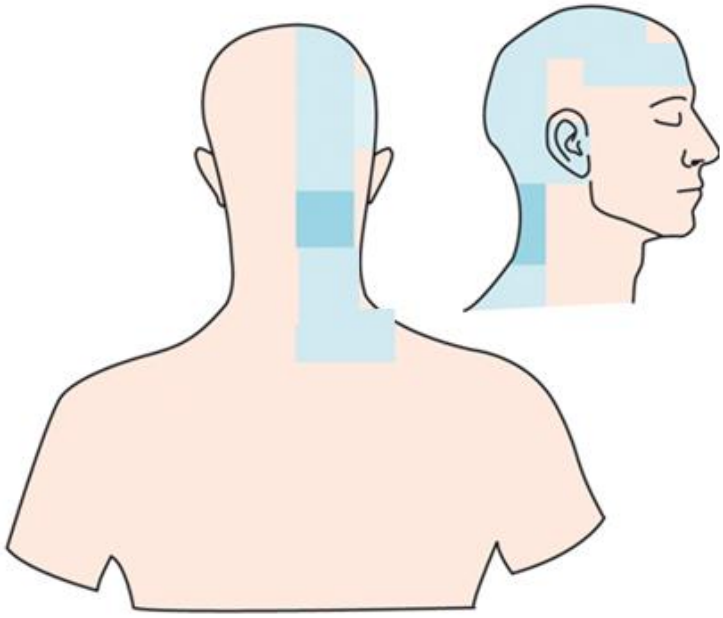


C2-3

The pain predominates on the side of the head and the superior part of the neck, the head and mainly the forehead.

☐ Check the box if C2-C3 fits your pain best.

95–100% 70–94% 45–69% 20–44%



C3-4

The pain predominates below the level between the ears and radiates to the shoulders, the top of the head and the forehead.

☐ Check the box if C3-C4 fits your pain best.