DuPage Medical Group Pediatrics

Screening Questionnaire for Recurrent Headache

PATIENT'S NAME _____ DATE OF BIRTH _____

Please check the appropriate answer:

1. How long have they been present?
   - _____ weeks
   - _____ months

2. Do the symptoms progress or are they the same?
   - _____ increase frequency
   - _____ increase intensity

3. How frequently do they occur?
   - _____ times per day
   - _____ times per week
   - _____ times per month

4. How long do they last?
   - _____ minutes
   - _____ hours

5. Do they occur at certain times?
   - _____ AM
   - _____ PM
   - _____ all day
   - _____ middle of night (wakes from sleep)
   - _____ upon awakening in AM
   - _____ other

6. Are there any associated symptoms?
   - _____ nausea
   - _____ vomiting
   - _____ visual disturbance (blurred vision, flashing lights, wavy lines)
   - _____ dizziness
   - _____ double vision

7. What is the quality of the headache?
   - _____ dull
   - _____ sharp
   - _____ pounding
   - _____ feels like "rubberband" around the head
   - _____ other

8. What is the location?
   - _____ front of head
   - _____ back of head
   - _____ right side
   - _____ left side
   - _____ all over
   - _____ moves around
   - _____ other
   - _____ one-sided or two-sided

9. Description, how bad? (1=mild, 5=medium, 10=worst possible)
   Please circle:
   mild 1 2 3 4 5 6 7 8 9 10 worst possible

10. Has there been any recent head injury? _____

11. Any specific recent stressful event, such as, school problems, divorce, family, etc? _____

12. Are there any methods that alleviate your headaches?
    - _____ what makes it feel better?
    - _____ makes it feel worse?
    - _____ does medication help?
    - _____ if yes, what?

13. Does anything seem to bring on the headaches?

_____ lack of sleep
_____ certain foods
_____ stress
_____ other

14. Do you miss favorite activities because of pain?

_____ yes
_____ no

15. Do you miss school because of your headaches?

_____ yes
_____ no

16. Does anyone in the family have headaches? Migraines? _____

_____

17. Do you have any additional comments?

_____

_____

_____

_____

SIGNATURE _____ DATE _____

Parent/Guardian