SELF ADMINISTERED HEADACHE QUESTIONNAIRE - AZIENDA SANITARIA LOCALE ROMA 1 - HEADACHE CENTRE

1. Date __/__/201_
2. Name and Surname
3. Age
4. Occupation
5. Is there anybody in your family who suffers from headache?
6. At what age did you have your first headache?
7. Did your headache change lastly?
8. How many headache attacks did you have per month, during the last six months?
9. How long does your headache last if you do not take any painkiller?
10. On which part of your head does the pain start?
11. Score the severity of you headache from 0-No Pain and 10-Worst Pain?
12. Describe what the headache is like, Eg: Heaviness, Burning, Throbbing, Stabbing, Tightness.
13. Is there any symptom that comes before the headache?
14. Is there any symptom that comes together with the headache, like tearing of your eyes, sickness or vomit, do bright light and noise bother you ?
15. What do you do during the attack?
16. Is there anything that triggers your headache?
17. What makes your headache get worse?
18. What makes your headache better?
19. What kind of painkillers do you take? Have you ever been prescribed treatments for your headaches?