Section A : Diagnostic

1- when did you start getting Headache ?

☐ As a child ☐ As a teenager ☐ 20's- 40's ☐ 50's -60's

2- How many attacks did you have in the last 30 days ?

☐1-3 ☐3-7 ☐7-10 ☐ more than 10

3-Do you experience any of the following before your headache begins ?

□ Mood changes □ Personality changes

□ Change in appetite □ Food cravings

□ Neck pain □ Fatigue

□ No, I don't experience any of these

□ Other _____

4- ***Do you ever experience any of these warning symptoms before your headache begins?***

□ Bright lights / flashes of lights/ multi-colored lights (circle applicable description)

□ Zig-zag lines □ Partial loss of vision / blurry vision / blindness (circle applicable)

□ Numbness / tingling □ Paralysis

□ Dizziness or vertigo □ Upset stomach / nausea □ No I don't have these

5- ***Do you experience any of these symptoms during your headaches?***

□ Nausea / upset stomach □ Vomiting

□ Bright lights/sun bothers you □ Loud sounds bother you

□ Strong smells/odors bother you

□ Dizziness / lightheadedness / vertigo (circle applicable description)

□ Numbness or tingling

□ Increased sensitivity of Scalp / Hair / Ears

□ Eye tears □ Runny or stuffy nose

□ Difficulty concentrating □ Mood changes / irritability

6- what are the precipitating/ triggers of the Headache attack ?

☐ Foods please mention them : _____

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☐ Too much caffeine ☐ not getting enough caffeine

☐Hunger / Skipping meals

☐Fatigue ☐Too little sleep ☐Too much sleep (sleeping in)

☐During stressful times ☐After stress (first day of vacation, weekend, after a test)

☐Menstruation

☐Exercise ☐Sexual activity ☐Coughing

☐Prolonged computer work ☐Weather changes

☐Certain Odors ☐Bright lights/sun ☐Loud sounds

Other _____

7- How often do you have Headache ?

They occur _____ times per ☐ day ☐ week ☐ month

8- Are they increasing in Frequency in the last month ?

☐ Yes ☐ No

9- When are the attacks more frequent ?

☐Weekdays ☐ weekends

☐ Spring ☐ summer ☐winter ☐ Autumn

☐ Morning ☐ afternoon ☐ Night

10- The onset of the attack is :

☐ Gradual ☐ sudden ☐ variable

11-How long does it take to reach the maximal intensity :

_____hours ____ minutes

12- How long does the attack last ?

Without medications _____ **Hours** ____ **minutes**

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With the medications _____ Hours ____ minutes

13- where do you feel the pain during your headaches ?

☐ **Left side of your head** ☐ **right side of your head**

☐ **Forehead** ☐ **temple** ☐**behind eyes** ☐ **back of your head**

14- Is your Headache on the same side of your head every time ?

☐ **Yes** ☐ **No**

15- Do your Headaches change in time of onset and pain character ?

☐ **yes** ☐ **No**

16 - What does the pain feel like ?

☐دماغي ☐ شواكيش☐ كهرباء☐ نبض☐فوران ☐ ضغط , ☐ نقح ☐ وجع منتشر ☐ حرقان ☐لسع هتنفجر

17- On scale from 1 to 10 , How bad is your pain ?

Answer : _____

1	2	3	4	5	6	7	8	9	10
☺				😐					☹

18- ***During a headache, what makes you feel the most comfortable?***

□ **Lying down / sleeping** □ **Being in a dark quiet room**

□ **Keeping physically active** □ **Pacing back-and-forth**

□ **Massage your head** □ **Tying something around your head**

□ **Cold pack on your head/neck** □ **Hot pack on your head/neck**

<u>Questions about the last attack</u>

19 - when was your last attack of headache ?

Answer ; _____

20- was this attack the same of the previous attacks ?

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□ **Yes** □ **No**

21- How long did it last ?

Answer : ____ Hours _____ minutes

22- How bad was the attack ?

□ **not bad** □ **quite bad** □ **very bad**

23 - was it during your work ?

□ **Yes** □ **No**

24- what treatment did you take for the last attack ?

Answer : _____

25- Was it helpful ?

□ **Yes** □ **No**

26- How long did it take to feel better after taking the medication ?

Answer : _____ Hours _____ minutes

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Section B: Management History

1- what are the Medications do you use ??

Medication	*Use per month*	*Helpful?*	*Tolerated?*
Eletriptan	x x		
Naratriptan	x x		
Sumatriptan	x x		
Zolmitriptan	x x		
Ergotamine	x x		
ketoprofen	x x		
ibuprofen	x x		
diclofenac	x x		
mefenamic acid	x x		
paracetamol	x x		
aspirin	x x		
Excedrin	x x		
Solpadeine	x x		
Metoclopramide	x x		
Domperidone	x x		
Feverfew	x x		
Other:	x x		

□ **other :** _____

2- Do you take a medication daily to prevent the Headache ?

□ **Yes** □ **No**

Mention it : _____

1- **Treatment used as prophylactic (to *prevent* headaches)?**

Treatment	*Dose*	*Helpful?*	*Tolerated?*
Propranolol			
Candesartan			
Amitryptalline			
Cyproheptadine			
Cinnarizine			
Verapamil			
Prednisolone			
Lithium			
Indomethacin			
Topiramate			
Valproate			
Levitracetam			
Lamotrigine			

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Carbamazepine			
Coenzyme Q10			
Magnesium			
Riboflavin			
Feverfew			
SSRI			
Duloxetine			
Botulinum Toxin			
Nerve block			
Erenumab			
Other:			

3-Have you ever seeked a medical advice about your Headache ?

□ **Yes** □ **No**

4- how many times in the past 1 year would you estimate that your headaches led to ?

□ **Absence from work** _____ **times**

□ **Visisting Emergency department** _____**times**

5- Which investigation have you done concerning your Headache ?

□ **C.T brain** □ **MRI brain** □ **x-ray of the neck**

□ **Blood tests mention them :** _____

□ **eye tests (for glasses)**

7- Have you in the last year been admitted to hospital because of your headaches ?

□ **Yes** □ **No**

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Section C: Depression and anxiety questions

Hospital Anxiety and Depression Scale (HADS)

		Most of the time	**A lot of the time**	**Time to time, occasionally**	**Not at all**
1-	**I feel tense or "wound up"**	3	2	1	0
		Nearly all of the time	**Very often**	**Sometimes**	**Not at all**
2-	**I feel as if I am slowed down**	3	2	1	0
		Definitely as much	**Not quite so much**	**Only a little**	**Not at all**
3-	**I still enjoy the things I used to enjoy**	0	1	2	3
		Not at all	**Occasionally**	**Quite often**	**Very often**
4-	**I get a sort of frightened feeling like "butterflies in the stomach"**	0	1	2	3
		Very definitely and quite badly	**Yes, but not too badly**	**A little, but it doesn't worry me**	**Not at all**
5-	**I get a sort of frightened feeling like something awful is about to happen**	3	2	1	0
		Definitely	**I don't take as much care as I should**	**I may not take quite as much care**	**I take just as much care as ever**

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6-	**I have lost interest in my appearance**	3	2	1	0
		As much as I always could	**Not quite so much now**	**Definitely not so much now**	**Not al all**
7-	**I can laugh and see the funny side of things**	0	1	2	3
		Very much indeed	**Quite a lot**	**Not very much**	**Not at all**
8-	**I feel restless as if I have to be on the move**	3	2	1	0
		A great deal of the time	**A lot of the time**	**From time to time but not too often**	**Only occasionally**
9-	**Worrying thoughts go through my mind**	3	2	1	0
		A much as I ever did	**Rather less than I used to**	**Definitely less than I used to**	**Hardly at all**
10-	**I look forward with enjoyment to things**	0	1	2	3
		Not at all	**Not often**	**Sometimes**	**Most of the time**
11-	**I feel cheerful**	3	2	1	0
		Very often indeed	**Quite often**	**Not very often**	**Not at all**
12-	**I get sudden feelings of panic**	3	2	1	0
		Definitely	**Usually**	**Not often**	**Not at all**
13-	**I can sit at ease and feel relaxed**	0	1	2	3
		Often	**Sometimes**	**Not often**	**Very seldom**
14-	**I can enjoy a good book or radio or TV programme**	0	1	2	3

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Scoring: Total score: Depression (D) _____ Anxiety (A) _____
0-7 = Normal

8-10 = Borderline abnormal (borderline case)

11-21 = Abnormal (case)

Examination

1- Visual acuity:
2- Fundus Examination: _____
3- Tender points:

☐ Occipital nerves ☐ supra-orbital/supratrochlear nerves ☐ auriculo-temporal nerves
☐ shoulders ☐ sternomastoid

☐ Other: _____

4- Sinus examination
5- Neck stiffness/tenderness
6- Signs of bruxism
7- Other neurologic findings: _____

Diagnosis

- Preliminary Diagnosis :

_____

- Final Diagnosis:

_____

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