Weill Cornell Medicine
Child Neurology

NewYork-Presbyterian
Phyllis and David Komansky
Children's Hospital

Pediatric Neurology

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PEDIATRIC HEADACHE QUESTIONNAIRE

Please complete this questionnaire. It will be an important part of your child's medical record.

Patient Name: _____ Today's Date: _____

DOB: _____ Age: _____ ☐ Male ☐ Female

How did you learn about our practice? _____

☐ **Pediatrician**: _____
Address: _____ Telephone: _____

☐ **Self-Referral (Internet/Family/Friend/Other)**

☐ **Referring Physician**: _____
Address: _____ Telephone: _____

Please bring to your appointment any and all reports of previous neurological testing or consultation, or reports of significant past medical problems.
If your child ever had a brain x-ray, CT, or MRI, please borrow the films or obtain a copy of the films and bring them with you to the visit.

The patient should complete these questions.
If a parent/guardian is completing this form, please make sure the responses are the patient's.

Headache History

Do you have more than one headache type?
☐ No
☐ Yes *(If yes, please answer the following questions for your first headache type, then describe your second headache on last page)*

1. **Are you ever headache free**: ☐ Yes ☐ No
   ☐ Vacation ☐ Weekends ☐ Weekdays ☐ Random ☐ Other _____
2. **Onset of First Headache:** Headaches started when I was _____ years old.
3. **Precipitating Events**
   What provoked your first headache? ☐ Nothing ☐ Injury ☐ Menarche (first period) ☐ Other: _____

4. Frequency:

How often does the headache occur?

☐ <1 /month ☐ 1 to 3 /month ☐ 1 /week ☐ 2 to 3 /week ☐ >3 /week

☐ Daily ☐ Continuous ☐ Other: _____

How many months has it been this frequent? _____

When are they most frequent?

☐ weekends ☐ weekdays ☐ vacation ☐ morning ☐ afternoon ☐ evening ☐ varies

Are they increasing in frequency: ☐ Yes ☐ No

5. Durations: How long do they last?

Lasts _____ minutes _____ hours _____ days (**with** medication)

Lasts _____ minutes _____ hours _____ days (**without** medication)

6. Severity: How bad is the pain? ☐ Mild ☐ Moderate ☐ Severe

On a scale of 0 to 10, what is the severity of your headache? (0 = no pain; 5 = moderate pain; 10 = worst possible pain)

Mildest: _____ Worst: _____

7. Location:

☐ front of head ☐ side of head ☐ back of head ☐ around eyes ☐ behind eyes ☐ all over

8. Sideness: Does your headache occur on:

☐ One side of your head ☐ Both sides ☐ Sometimes on one side and sometimes on both sides

9. Character: What does the pain of the headache feel like?

☐ Throbbing ☐ Squeezing ☐ Stabbing ☐ Pinching ☐ Pressure ☐ Burning ☐ Sharp ☐ Dull

Other: _____

Does the pain usually feel like it is going: ☐ in ☐ out ☐ both ☐ can't tell

10. Activity that worsens headache:

Does the headache change your activity level (i.e., stop playing or doing normal activities)?	☐ Yes	☐ No
Does activity or playing make the headache worse?	☐ Yes	☐ No
Does the headache hurt more when you walk up stairs?	☐ Yes	☐ No
Does bending over or standing up make it worse?	☐ Yes	☐ No
Does straining or coughing make it worse?	☐ Yes	☐ No
Does resting or sleeping make your headache get better or go away?	☐ Yes	☐ No

11. What symptoms occur with the headache? *(Please review carefully and check)*

☐ Nausea ☐ Vomiting ☐ Sensitivity to light ☐ Sensitivity to sound ☐ Sensitivity to smells ☐ Lightheadedness

☐ Spinning sensation ☐ Tearing eyes ☐ Runny nose ☐ Decrease appetite ☐ Stomach pain ☐ Fatigue

☐ Ringing in the ears ☐ Changes in vision ☐ Confusion ☐ Difficulty with - thinking / walking / using arms / talking

Other _____

12. Do you have any changes in your vision before your headache begins? *(Questions for visual aura)*

☐ zigzag lines ☐ flashing lights ☐ loss of vision on one side ☐ blurry vision

☐ tunnel vision ☐ double vision ☐ total blindness ☐ other changes in vision: _____

How long do the symptoms last? _____ minutes _____ hours

How soon after your headache starts do these symptoms begin? _____Minutes

Do you have any of these symptoms without headache pain? ☐ Yes ☐ No

13. Premonitory Symptoms

Do you experience any of the following BEFORE the headache starts?

☐ Tired ☐ Irritable ☐ Hyperactive ☐ Depressed ☐ Feeling "Not right" ☐ Food cravings

☐ Extremely talkative ☐ Difficulty with speech ☐ Sunken eyes ☐ Flushed face ☐ Diarrhea ☐ Constipation

How long before the headache starts do you notice these signs? _____ ☐ minutes ☐ hours ☐ days

14. Provoking Factors: (things that bring on a headache)

Food/beverage: ☐ fasting ☐ chocolate ☐ caffeine ☐ cold cuts ☐ other: _____

Physical exertion: ☐ coughing ☐ talking ☐ chewing ☐ exercise

Hormonal: Menses: ☐ before ☐ during ☐ after

Stress: ☐ school ☐ home ☐ other: _____

Environmental: ☐ allergies ☐ weather changes ☐ altitude ☐ sunlight ☐ smells ☐ light

☐ noises other: _____

Sleep: ☐ lack of sleep ☐ too much sleep ☐ change in wake/sleep

Other triggers: _____

15. Relieving Factors:

☐ lying down ☐ dark quiet room ☐ hot compress ☐ cold compress ☐ keeping active/pacing

☐ standing ☐ massage ☐ other: _____

16. Do you experience any of the following during your headache

☐ Numbness/Tingling- Right ☐ Unable To Speak ☐ Double Vision
☐ Numbness/Tingling- Left ☐ Decreased Consciousness ☐ One-Sided Weakness
☐ Numbness/Tingling- Both ☐ Unsteadiness/Severe Dizziness

17. Have you noticed any of these findings when you have a headache ?

It hurts when you touch/comb your hair	☐ Yes	☐ No	☐ N/A
It hurts when you wear as ponytail	☐ Yes	☐ No	☐ N/A
You get sinus pressure	☐ Yes	☐ No	☐ N/A
You get pain over your sinuses	☐ Yes	☐ No	☐ N/A
Your neck feels tight/stiff	☐ Yes	☐ No	☐ N/A

Quality of Life Review:

1. My appetite lately is: ☐ increased ☐ decreased ☐ no change

2. My energy level lately is: ☐ increased ☐ decreased ☐ no change

3. Headache's effect on ability to function:

At what percentage are you able to function when you get a headache at school?

☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0%

At what percentage are you able to function when you get a headache playing?

☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0%

Previous treatments: (please give name of provider, date, type of treatment and if it helped)

	Name of Provider, Date, Type of Treatment
Primary Care Provider	
Neurologist	
Otolaryngologist (ENT)	
Dentist / Dental	
Ophthalmologist	
Psychiatrist / Psychologist	
Biofeedback / Relaxation	
Physical Therapy	
Massage	
Herbal / Homeopathic Medicine	
Other	

Did they diagnose your headache? ☐ Yes ☐ No

What diagnosis? _____

Previous Tests: (Please give dates and results)

Test	**Date**	**Result (Normal or Abnormal)**
Brain MRI		
MRA / MRV		
Cervical MRI		
Head CT		
EEG		
Lumbar Puncture		
EMG		
Sleep Study		

Previous Preventive Headache Medication: (please check any medication that you have taken every day for your headache)

- ☐ Elavil (Amitriptyline)
- ☐ Pamelor (Nortriptyline)
- ☐ Topamax (Topiramate)
- ☐ Inderal (Propranolol)
- ☐ Other B-blocker
- ☐ Clonidine (Kapvay)
- ☐ Calan (Verapamil)
- ☐ Periactin (Cyproheptadine)
- ☐ Depakote (Valproic Acid)
- ☐ Neurontin (Gabapentine)
- ☐ Risperdal (Risperidone)
- ☐ Abilify
- ☐ Seroquel
- ☐ Zyprexa
- ☐ Lamictal
- ☐ Tegretol (Carbamazepine)
- ☐ Zonegran
- ☐ Keppra
- ☐ Lithium
- ☐ Ativan
- ☐ Klonopin (Clonazepam)
- ☐ Botox injections
- ☐ Trigger point injections
- ☐ Greater Occipital Nerve blocks

Previous Abortive Headache Medication (please check any medication that you have taken for your headache)

- ☐ Advil (ibuprofen)
- ☐ Aspirin
- ☐ Aleve
- ☐ Benadryl (diphenhydramine) ☐ Celebrex
- ☐ Daypro
- ☐ Navane (thiothixene) ☐ Thorazine (chlorpromazine)
- ☐ Toradol (ketorolac) ☐ Relafen (ketoprofen)
- ☐ Voltaren (diclofenac)
- ☐ Orudis
- ☐ Compazine (Prochlorperazine) ☐ Phenergan (promethazine) ☐ Tigan
- ☐ Haldol
- ☐ Medrol Dose Pak ☐ Prednisone (prednisolone)
- ☐ Decadron (dexamethasone) ☐ Soma
- ☐ Excedrin ☐ Flexeril ☐ Midrin
- ☐ DHE ☐ Migranal ☐ Ergotamine suppositories
- ☐ Amerge ☐ Axert
- ☐ Tylenol
- ☐ Anaprox (naproxen sodium)
- ☐ Cataflam ☐ Naprosyn ☐ Vioxx
- ☐ Indocin (indomethacin)
- ☐ Motrin (ibuprofen)
- ☐ Codeine ☐ Darvocet ☐ Duragesic patch
- ☐ Bellergal
- ☐ Frova ☐ Maxalt
- ☐ Darvon ☐ Methadone ☐ OxyContin ☐ Stadol
- ☐ Cafergot
- ☐ Fioricet with codeine ☐ Fiorinal
- ☐ Imitrex ☐ Imitrex injections ☐ Relpax
- ☐ Demerol ☐ Morphine ☐ Percocet ☐ Vicodin
- ☐ Fiorinal with codeine
- ☐ Imitrex nasal spray
- ☐ Zomig
- ☐ Zofran ☐ Zyprexa

☐ Other pain medication: _____

Vitamins, other supplements or herbal medications for headaches:

☐ Coenzyme Q ☐ Magnesium ☐ Vitamin B2 (Riboflavin) ☐ Petadolex (Butterbur) ☐ Feverfew

☐ Melatonin ☐ Other: _____

Have you ever been treated for your headaches in an emergency department? ☐ Yes ☐ No

Have you ever been treated for your headaches in a hospital (stayed overnight)? ☐ Yes ☐ No

Current Medications: (Bring your own medication list and dosing schedule if more than 5)

Medication	**Dose**	**How often**

Allergies: ☐ foods ☐ medicines ☐ dye/iodine ☐ other, please list: _____

If allergic, what reaction did you have? ☐ skin rash ☐ breathing ☐ stomach ☐ other: _____

Habits: Eating:

Do you skip any meals? ☐ Yes ☐ No Which meals do you skip? ☐ Breakfast ☐ Lunch ☐ Dinner

Do you regularly eat meat? ☐ Yes ☐ No

Do you regularly eat/drink dairy? ☐ Yes ☐ No

Do you regularly eat vegetables? ☐ Yes ☐ No

Drinking:

How much total fluids do you drink a day? _____(# of total ounces) or _____(# of glasses)

Do you drink caffeine-containing beverages? ☐ Yes ☐ No How many days per week? _____

Do you carry a water bottle? ☐ Yes ☐ No

Exercise: Do you exercise? ☐ Yes ☐ No

How long do you usually exercise per day? _____minutes / hours (please circle)

Sleeping: I get _____hours of sleep per night.

Check all that apply:

- ☐ I have no trouble falling asleep
- ☐ I have difficulty falling asleep
- ☐ I have trouble staying asleep
- ☐ I sleep too much
- ☐ I wake up during the night or early morning for no apparent reason
- ☐ My headache awakes me
- ☐ I wake up with a headache
- ☐ I snore

Weekdays: Bedtime _____ Wake up time _____

Weekends: Bedtime _____ Wake up time _____

Past Medical History:

What was the patient's birth weight? _____lbs _____ounces

Was the patient born prematurely? ☐ Yes ☐ No If yes how many weeks premature? _____

Were there any problems during delivery? ☐ Yes ☐ No

If yes, please describe: _____

Was your development normal? ☐ Yes ☐ No

If no, please explain: _____

Have you ever been diagnosed with any medical or psychiatric problems?

☐ Head trauma ☐ Brain infections ☐ Seizures ☐ Strokes ☐ ADD/ADHD ☐ Asthma
☐ Seasonal allergies ☐ Recurrent sinusitis ☐ Depression ☐ Anxiety

Hospitalizations: _____

Surgeries: _____

Have you had any of the following problems?

☐ Motion/Car sickness ☐ Difficulty sleeping ☐ Sleep walking ☐ Sleep talking
☐ Night terrors ☐ Snoring ☐ Unexplained fevers
☐ Repeated episodes of stomach pain or vomiting (without headache) ☐ GE Reflux ☐ Fainting spells
☐ Feeling anxious ☐ Feeling depressed ☐ Shyness ☐ Feelings of low self-esteem
☐ Worrying a lot

(For female patients) Menstrual History:

At what age did your menstrual periods start? _____ Menses occur monthly: ☐ Yes ☐ No

Last menstrual period:_____

Are your headaches worse with your periods? ☐ Yes ☐ No ☐ Not sure

If you haven't had a period OR they just started, do you have monthly headaches? ☐ Yes ☐ No ☐ Not sure

Are you on birth control? _____

Social History

Who lives in the same house with the patient?

Name	Age	Relationship To Patient

Are the parent(s) ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Remarried

What grade are you currently in at school? _____

School performance (i.e grades) _____

Have your headaches caused your academic performance to change? ☐ Yes ☐ No

School Type: ☐ Public ☐ Private ☐ Home schooled ☐ College

Difficulty at school with: ☐ Bullies ☐ Homework ☐ Grades

Any unusual stresses at home or at school? ☐ No ☐ Yes

Are you (patient) employed? ☐ Yes ☐ No

If so, what is your occupation? _____

Have your headaches caused your work performance to change? ☐ Yes ☐ No

Any drug use/abuse? ☐ Yes ☐ No Alcohol use/abuse? ☐ Yes ☐ No

Tobacco use/abuse? ☐ Yes ☐ No Sexually active? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

Family History

Please check the box if your family members have had ANY of the following and list the person's relationship to the patient next to the problem:

☐ Migraine headaches
☐ Headaches (any type)
☐ Seizures
☐ Mental retardation
☐ Developmental delay
☐ Speech delay
☐ Attention Deficit
☐ Learning Disabilities
☐ Autism
☐ Brain Tumors
☐ Hypertension
☐ Heart Disease
☐ Strokes
☐ Psychiatric Disorder
☐ Addiction Disorder
☐ Genetic disorder
☐ Other diseases:

Review of Systems: *(please check)*

☐ Eyes ☐ Ears ☐ Nose ☐ Throat ☐ Heart problems ☐ Chest pains

☐ Trouble breathing ☐ Shortness of breath ☐ Wheezing ☐ Stomach ☐ Pains

☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Urination ☐ Muscle

☐ Aches ☐ Arm pain ☐ Leg pain ☐ Joint pain ☐ Back pain

☐ Bleeding problems ☐ Fever ☐ Colds ☐ Coughs ☐ Weight changes

☐ Rashes ☐ Skin changes

If you have more than one headache type, please use this space for your second headache:

Describe your second headache type:

____

PedMIDAS** (Pediatric Migraine Disability Assessment)

The following questions try to assess how much the headaches are affecting day-to-day activity. Your answers should be based on the **last three months**. There are no "right" or "wrong" answers so please put down your best guess.

1. How many full school days were missed in the last 3 months due to headaches?	
2. How many partial days of school were missed in the last 3 months due to headaches (do not include full days counted in the first question)?	
3. How many days in the last 3 months did you function at less than half your ability in school because of a headache (do not include days counted in the first two questions)?	
4. How many days were you not able to do things at home (i.e., chores, homework, etc.) due to a headache?	
5. How many days did you not participate in other activities due to headaches (i.e., play, go out, sports, etc.)?	
6. How many days did you participate in these activities, but functioned at less than half your ability (do not include days counted in the 5th question)?	
Total PedMIDAS Score	

PLEASE DRAW WHAT IF FEELS LIKE WHEN YOU GET A HEADACHE

X

Parent/Guardian/Patient Signature **Date**

X

Physician Signature **Date**

Please return this questionnaire to pedsneurotele@med.cornell.edu prior to the doctor's visit.

**This questionnaire is modified from Jefferson Headache Center and Cincinnati Children's Hospital Headache Center Questionnaires and authored by Zuhal Ergonul, MD. PhD.*
***PedMIDAS: Development of a questionnaire to assess disability of migraines in children. Hershey AD, Powers SW, Vockell AL, LeCates S, Kabbouche MA, Maynard MK. Neurology. 2001 Dec 11;57(11):2034-9.*

Race and Ethnicity Information

We want to make sure that all our patients get the best care possible. We would like you to tell us your child's racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

Primary Language

- ☐ Albanian
- ☐ American Sign Language
- ☐ Arabic
- ☐ Armenian
- ☐ Bengali
- ☐ Bosnian
- ☐ Cantonese (Chinese)
- ☐ Creole
- ☐ Croatian
- ☐ ECH
- ☐ Danish
- ☐ English
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Hebrew
- ☐ Hindi
- ☐ Indonesian
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Latin
- ☐ Malay
- ☐ Mandarin (Chinese)
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Romanian
- ☐ Russia
- ☐ Serbian
- ☐ Slovak
- ☐ Spanish
- ☐ Swahili
- ☐ Swedish
- ☐ Tagalog
- ☐ Thai
- ☐ Turkish
- ☐ Urdu
- ☐ Vietnamese
- ☐ Yiddish
- ☐ Yugoslavian
- ☐ Other
- ☐ Declined
- ☐ Unknown

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Island
- ☐ White
- ☐ Other Combination Not Described
- ☐ Declined

Ethnicity

- ☐ Hispanic or Latino or Spanish Origin
- ☐ Not Hispanic or Latino or Spanish Origin
- ☐ Declined

Pharmacy Information

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

☐ New

Date:

Patient Name:

NYH #:

PRIMARY
Pharmacy Name:

Address:

Phone Number:

Fax Number:

SECONDARY (if applicable)
Pharmacy Name:

Address:

Phone Number:

Fax Number:
