PATIENT NAME: _____ DATE: _____

GILBERT HEADACHE QUESIONNAIRE

Answer all questions, yes or no, with a check mark

YES	NO	
☐	☐	1. Do you have an idea of what may be causing your headache? (Whiplash, diabetes, high blood pressure, eye strain, etc.)
☐	☐	2. Did this same type of headache ever occur before?
☐	☐	3. Do you have more than one type of headache?
☐	☐	4. Is the headache pain so intense that sometimes it becomes unbearable?
☐	☐	5. Do your headaches occur during stressful tension or nervousness at home, at work, or during social occasions?
☐	☐	6. Do your neck, shoulder muscles or head junction feel tight and painful during the headache?
☐	☐	7. Is your headache pain dull and steady, like an intense constant pressure?
☐	☐	8. Does your headache feel like a tight band around the head?
☐	☐	9. Do you usually have one (1) or more headaches per week?
☐	☐	10. Do your headaches occur during the day?
☐	☐	11. Does mother, father or any blood relative have similar headaches?
☐	☐	12. Does exertion (lifting, running, straining, sex) affect your headache?
☐	☐	13. Does nausea and/or vomiting occur before or during your headache?
☐	☐	14. Do you have any changes in vision (flashing lights, sensitivity to light, spots, blurred vision, etc.) before or during you headache?
☐	☐	15. Does your headache usually start on one side of the head?
☐	☐	16. Does your headache throb and pulsate or feel like it is pounding?
☐	☐	17. Do your headaches usually occur during the night or upon awakening?
☐	☐	18. Do your headaches usually occur during weekends and holidays?
☐	☐	19. (Females only) Is your headache associated with your menstrual period?
☐	☐	20. Do you have watering of the eye on the affected side of the headache?
☐	☐	21. Do alcoholic drinks cause or aggravate your headaches?
☐	☐	22. Does chocolate, cheese, milk, nuts, Chinese food or any other food cause or worsen your headaches?
☐	☐	23. Do you have any hearing problems – noise, drainage or stuffiness in either ear?
☐	☐	24. Have you noticed any paralysis, muscle weakness, numbness, swallowing problems or speech changes during your headaches?
☐	☐	25. Do you have any facial pain, aching jaws, stuffiness or congested sinuses along with your headache?
☐	☐	26. Has it been over eighteen (18) months since you last visited a dentist?
☐	☐	27. Have you had tests for headache? (X-Ray, brain scans, injections, etc?)
☐	☐	28. Have you used any previous headache medication? List all medications on the back of this form.