Headache Questionaire for 1. appointment

KOPFSCHMERZ ZENTRUM FRANKFURT

Dear patient,

to optimize your headache treatment and to take all your needs in account we kindly ask you to fill in this questionaire. Please complete all blanks, choose those answers which best describe your situation.

Please do not hesitate to ask if you have any questions.

Family Name, first name: _____ **Date of birth:** _____

Filled in on: _____ **Healthcare insurance:** _____

From whom did you get the recommendation to come to the Headache Center?

☐ personal physician ☐ Pain therapist ☐ Healthcare insurance ☐ Internet ☐ patient support group (z. B. MigräneLiga)

other: _____

Who is your personal physician?

_____

Which specialist do/ did you see because of your headaches?

_____

_____

_____

Questions about your headache characteristics

At what age did the headache first occur?

At the age of _____ years.

Do any other family members suffer from recurrent headaches?

○ No ○ yes, my _____ suffers from:

☐ migraine ☐ tension type headache ☐ cluster headache ☐ trigeminal neuralgia

On how many days in the last 4 weeks did you suffer from headaches? (please add up all days including those with low and high pain level)

Number of days _____

How intense were the headaches on average during the last 4 weeks?

Please choose a number between 0 (pain free) and 10 (maximum pain intensity): _____

What was the maximum pain intensity during the last 4 weeks?

Please choose a number between 0 (pain free) and 10 (maximum pain intensity): _____

How quickly did the pain usually reach its maximum after it started?

Within _____ minutes

How long do the headache attacks last without any treatment?

_____ minutes _____ hours _____ days

At which time do the headaches usually occur?

☐ they wake me up while sleeping ☐ early morning ☐ forenoon ☐ afternoon ☐ evening

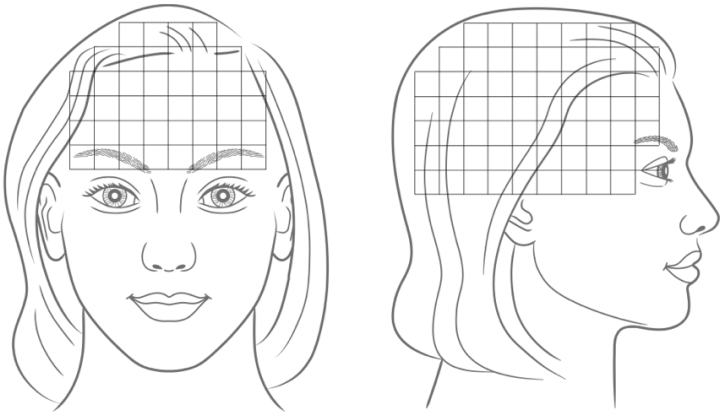
Do you have single attacks in the early morning? ○ No ○ yes

Are there any regular time features in the headache attacks (example: every day at the same time)?

○ irregularzu ○ always at the same time, about ____o'clock

How often do the headaches occur? _____ times per day _____ per month

Where is the pain located?
(p*lease mark on the drawingitte*)



Which accompanying symptoms do you have with the headache attacks?

☐ nausea ☐ mild or ☐ severe? ☐ sensitivity to light ☐ runny nose

☐ vomiting ☐ mild or ☐ severe? ☐ sensitivity to noise ☐ watery eyes

☐ need for rest ☐ sensitivity to odors ☐ restlessness /need to move

☐ others: _____

Have you seen a specialist because of your headaches?

○ no

☐ general practitioner ☐ ENT specialist ☐ ophthalmologist

☐ neurologist ☐ gynecologist ☐ neurosurgeon

☐ dentist ☐ psychiatrist ☐ orthopedic surgeon

☐ other: _____

Did you ever have psychotherapy because of your headache complaints?

○ no ○ yes, in the year: _____ duration of therapy: _____

Did you ever have inpatient treatment in a hospital or rehabilitation center because of your headaches?

○ no ○ yes, when? _____

Did you undergo any futher technical examinations because of your headaches?

○ No

☐ computed tomography (CT-scan)of the head? ☐ X-ray of paranasal sinus

☐ MRI of the head ☐ X-ray of the cervical spine

☐ computed tomography (ct-scan)of the cervical spine/neck ☐ Holter ECG or Holyer blood pressure measurement

☐ MRI of the cervical spine/neck ☐ sonography of the cervical arteries

☐ lumbar puncture ☐ other: _____

Have you recognized (besser identified) any triggers or increasing mechanisms of your headache attacks/intensity?

○ no

☐ stress ☐ after stress ☐ lack of sleep/sleep disturbances

☐ irregularity of daily routine ☐ night shift, shift work ☐ menstruation

☐ alcohol ☐ sports, physical activities ☐ weather ☐ odors

☐ food, which: _____

☐ other: _____

Acute treatment of headache attacks

Was oxygen prescribed for headache treatmnet during the last 6 month?

○ no ○ yes

Do you take any drugs for acute treatment of headache attacks?

○ no

Drug group	Example (oral, nasal, subcutaneous)	Brand name	Number of dayswith use during the last 4 weeks
☐ **painkiller**	Paracetamol, Aspirin, Ibuprofen, Diclofenac, Metamizol	Novalgin®	
☐ **combination analgesics**	Acetylsalicylsäure, Paracetamol and Coffein (acetylsalicylic acid, paracetamol, caffeine)	Excedrin®Thomapyrin®	
☐ **triptansTriptane:**			
☐ Sumatriptan	Tabl. / nasal spray subcutaneus injection	Imigran Tabl.® Imigran Nasal® Imigran-Injekt® MigraPEN® Tempil	
☐ Rizatriptan	Tabl. / orodispersible tablet	Maxalt®	
☐ Zolmitriptan	Tabl. / orodispersible tablet/ nasal spray	AscoTop®	
☐ Eletriptan	Tabl.	Relpax®	
☐ Almotriptan	Tabl.	Dolortriptan®	
☐ Naratriptan	Tabl.	Formigran® Naramig®	
☐ Frovatriptan	Tabl.	Allegro®	
☐ **opioids**	Tramadol, Tilidin, Naloxon	Tramal®, Valoron N®	
☐ **others:**			

Do you have headache attacks which do not respond to acute therapy?

○ no ○ yes, especially when (describe situation)?

_____

If you suffer from significant nausea and vomiting, do you vomit the drugs?

○ no ○ yes

Do you take any additional drugs against nausea and vomiting?

○ no

☐ Domperidon (Motilium®) ☐ Metoclopramid (Paspertin®) ☐ Dimenhydrinat (Vomex®)

Prophylactic medication

Are you currently taking any daily medication to prevent headache?

○ no

Substance or brand:	dose:	Intake since (month/year):
1.		
2.		
3.		
4.		
5.		
6.		

Did you ever take one of the following substances for headache prophylaxis for a minimum of 4-8 weeks?

Drug	Example	Dose?	Efficacy? Tolerability?
☐ CGRP-monoclonal antibodies	Erenumab (Aimovig®) Galcanezumab (Emgality®) Fremanezumab (Ajovy®)		○ lack of efficacy ○ not tolerated
☐ Betablocker	Metoprolol, Bisoprolol, Propanolol		○ lack of efficacy ○ not tolerated
☐ Topiramat	Topamax®		○ lack of efficacy ○ not tolerated
☐ valproic acid	Valproat®, Ergenyl®		○ lack of efficacy ○ not tolerated
☐ Carbamazepin	Tegretal®		○ lack of efficacy ○ not tolerated
☐ Pregabalin	Lyrica®		○ lack of efficacy ○ not tolerated
☐ Calcium antagonist	Flunarizin (Natil N®) Verapamil (Isoptin®)		○ lack of efficacy ○ not tolerated
☐ Amitriptylin	Saroten®, Equilibrin®		○ lack of efficacy ○ not tolerated
☐ Opipramol	Insidon®		○ lack of efficacy ○ not tolerated
☐ Duloxetin	Cymbalta®		○ lack of efficacy ○ not tolerated
☐ Venlafaxin	Trevilor®		○ lack of efficacy ○ not tolerated
☐ Citalopram	Cipramil®		○ lack of efficacy ○ not tolerated

☐ Candesartan	Atacand (Protect)®		○ lack of efficacy ○ not tolerated
☐ botox injections	Botox®	Wie oft? How often?	○ lack of efficacy ○ not tolerated
☐ Lithium	Hypnorex®, Quilonum®		○ lack of efficacy ○ not tolerated
☐ Magnesium			○ lack of efficacy ○ not tolerated
☐ butterbur	Petadolex®		○ lack of efficacy ○ not tolerated
☐ nutritional supplements	Orthoexpert, Migra3, Migravent		○ lack of efficacy ○ not tolerated
☐ others	Name:		○ lack of efficacy ○ not tolerated
☐ others	Name:		○ lack of efficacy ○ not tolerated

Other interventions for headache prophylaxis

Do you perform endurance training regularly (2-3 times per week for a minimum of 30 minutes)?

○ no ○ yes, which: _____

Do you perform realxation training regularly (2-3 times per week for a minimum of 30 minutes), examples: autogenic training, muscle relaxation, yoga?

○ no ○ yes, which: _____

Have you received other therapies against your headaches?

○ No

☐ massages: ☐ osteopathy:

☐ physiotherapy: ☐ accupuncture:

☐ manual: ☐ others:: _____

Comorbid disorders, sleep disturbances

Do you have any concomitant diseases?

○ No

☐ joint pain, rheumatism
☐ allergies, hay fever, asthma
☐ high blood pressure
☐ myocardial infarction, coronary heart disease
☐ stroke
☐ anxiety disorder/panic attacks
☐ posttraumatic stress disorder
☐ eating disorder
☐ gastric ulcer, gastrointestinal bleeding
☐ chronic bronchitis
☐ muscle pain
☐ chronic abdominal pain
☐ depression
☐ tinnitus
☐ kidney disease

☐ other: _____

Do you suffer from sleep disturbances?

○ No

☐ difficulties falling asleep ☐ problems staying asleep ☐ snoring, Pickwick Syndrom

foodstuffs, drinks and tobacco

Do you smoke?

○ no ○ occasionally ○ regularly for _____ years _____ cigarettes per day

Do you drink alcohol?

○ no ○ occasionally ○ regularly for _____ years

Amount of alcohol per day/which drinks (beer, wine, others?) _____

How many cups of coffee / energy drinks containing caffeine do you drink per day (on average)? (one mug = 2 cups)

Number of cups: _____

Personal data

How tall are you? _____cm How much do you weigh? _____ kg

Please provide information about your family status? (answer optional)

○ single ○ married ○ living with a partner ○ divorced ○ widowed

Are you employed? How many hours per week? *(answer optional)*

○ employed ○ self-employed ○ pensioned ○ unemployed ○ in vocational training ○ student

○ pupil ○ working full time Vollzeit ○ part-time on job ____hours per week

Do you suffer from family or job stress?

○ no ○ yes (please explain to the doctor)

Do you have shift work?

○ no ○ yes including night shifts ○ morning/late shift/alternate shift

Have you been unable to go to school/university/work during the last 4 weeks? Did you get a disabilitycertificate from your doctor or did you use vacation days to stay away from work?

○ no ○ yes, on___ days

Have you been in early retirement due to headache during the last 6 months?

○ no ○ yes, completely ○ yes partly

Do you have a severely handicapped pass?

○ no ○ yes, degree (GdB):___

Thank you very much for your cooperation!

May we contact you in case of additional questions?

Yes, by phone: _____ by email: _____