UNIVERSITY of ROCHESTER MEDICAL CENTER

GOLISANO CHILDREN'S HOSPITAL

New Patient: PEDIATRIC HEADACHE QUESTIONNAIRE

Please complete this questionnaire prior to your appointment. It will be used during the appt & become an part of the medical record. Teens should complete as much as they can independently.

Patient Name_____ Age___ Date of Birth_____ Today's D ate_____

Address_____ ☐Male ☐ Female

Home ph _____ Cell ph _____ Work ph _____

Pediatrician name _____

How did you hear about our practice?

☐Pediatrician referral ☐ Self referral (Internet/ Family/Friend) ☐ Other _____

Please bring any and all reports of previous neurological testing, consultation that was done outside the University of Rochester/Golisano Children's Hospital health system. If the patient has ever had a brain CT, MRI please obtain a copy of the films for the neurologist to review and to add to the medical record .

Please describe why you are bringing your child for evaluation today:

_____

_____

_____

_____

_____

_____

1. Previous Evaluations

Check all that apply	Type of Evaluation	Approx. Date	Provider Name/Location
	Neurologist		
	Ear/Nose/Throat specialist		
	Psychologist/Psychiatrist/Counselor		
	Physical Therapy		
	Massage		
	Acupuncture /Chiropractor		
	Relaxation / Biofeedback		
	Herbal / Homeopathic medicine		
	Other		

2. Previous Testing

Check all that apply	Test	Date	Result
	Important!: Date of last dilated eye exam by Ophthalmologist		
	MRI		
	MRA / MRV		
	Head CT		
	Lumbar Puncture		
	Sleep Study		
	Sinus films		
	Other?		

3. Current Medications:

Medication	For what? (headache,ADHD,asthma,etc)	Pill size(mg) or concentration (mg/ml)	Dose	Times per Day

4. Was a diagnosis made for a certain type of headache?(if yes, what type & by who)

5. Has the patient been on daily **Preventative Headache Medications** in the past? ☐ **NO** (if YES, which ones? Please check all that apply) ☐ Elavil (Amitriptyline) ☐ Pamelor (Nortriptyline) ☐ Topamax(Topiramate) ☐ Inderal (Propranolol) ☐ Periactin (cyproheptidine) ☐ Depakote (Valproic acid) ☐ Neurontin (Gabapentine) ☐ Calan (Verapimil) ☐ Other_____

6. **Abortive Medications:** What medications have been used to treat headache pain? ☐ **None**
☐ Advil/Motrin (ibuprofen) ☐ Tylenol (acetaminophen) ☐ Aleve/Anaprox (Naproxen) ☐ Aspirin ☐ Benadryl(diphenhydramine) ☐ Compazine(prochlorperazine) ☐ Zofran (Ondansetron) ☐ Phenergan (promethazine) ☐ Indocin (Indomethacin) ☐ Imetrex (sumatriptan) ☐ Zomig (zolmitraptan) ☐ Maxalt (Rizatriptan

   a. **About how many doses of pain reliever medications have you needed to use over the last 4 weeks?**
   _____

7. **Vitamins or Supplements:** Have you used nutritional supplements to manage the headaches? ☐ **NO**
☐ Magnesium ☐ Vitamin B2 (Riboflavin) ☐ Petadolex (Butterbur) ☐ Feverfew ☐ Melatonin ☐ Co Q10 ☐ Other_____

8. **Emergency Room Care:** have you ever been treated in a hospital Emergency Room for your headaches?
☐ No ☐ Yes *(where & when was the last time?)* _____

9. **Have you ever been hospitalized for headache (overnight)?** ☐ No ☐ Yes_____

10. Past Medical History

a. Any problems during **pregnancy/delivery** of this child? ☐ NO ☐ **Yes** _____

b. **Infancy:** Birth Weight _____ lbs _____ oz Born premature? ☐ NO ☐ Yes - How much? _____wks premature

c. Were there health problems during **infancy?** ☐ NO ☐ Yes – what kind? _____

d. List **illnesses** during childhood for this child _____

e .**Development:** Were there any problems with development? (Not sitting, walking, talking, etc as expected)
☐ NO ☐ Yes – what kind? _____

Was/Is Early Intervention Services involved? NO Yes -→ circle all that apply OT / PT / Speech

Any Hospitalizations or Surgeries?

Date	Age	Illness / Surgery	Hospital

ROS: **Has this child ever had any of the following problems?**

General health: ☐ Missed a significant amount of school due to headaches

Head: ☐ Concussion/Head injury history ☐ Abnormal head size (too large / too small)

Eyes: ☐ Wears corrective lenses ☐ Double vision ☐ Other (describe) _____
☐ Vision changes with headaches (circle all that apply): Blurry -Glare - Flashing lights - Zigzag lines- Tunnel vision
Other eye conditions: _____

Ears / Nose / Throat: ☐ Hearing problems ☐ Recurrent sinus infections ☐ Recurrent strep throat

Other Ear/Nose/Throat conditions _____

Skin: ☐Eczema ☐Acne ☐ Patches of brown/red/pale skin ☐ Significant birthmarks (dark or light patches of skin)

Heart: ☐ Murmur ☐Skipped beats/arrhythmias ☐Heart defect ☐High/Low Blood Pressure

Other cardiac condition_____

Breathing: ☐Asthma ☐Recurrent sinus Infections ☐ Snoring ☐ Pauses in breathing during sleep

Other respiratory condition _____

Digestive:

☐Recurrent episodes of nausea/vomiting with headaches ☐ Cyclic vomiting ☐ Gastric Reflux

☐ Recurrent stomach pain ☐Other digestive concerns _____

Muscles /Bones /Joints:

☐Numbness/tingling w/ headaches ☐Episodes of muscle weakness w/ headache (one-sided or both sides?)

Other skeletal conditions _____

Hormonal/ Endocrine/ Bleeding:

☐Thyroid problems -Low / High ☐Growing too slow ☐Easy bleeding/bruising ☐ Eating disorder

☐Frequent bloody noses ☐ Diabetes ☐ Obesity ☐ Sudden weight loss

Other hormone or blood-related conditions? : _____

ADOLESCENT GIRLS: Age of onset of menstrual periods ____ yrs Are periods regular? ☐ Yes ☐ No

Has the patient ever been on birth control pills or Depo shots? ☐ No ☐Yes→ Did headaches worsen or improve after beginning these medications? _____ Are you on this medicine now? ☐ Yes ☐ No

Neurologic : *Has the child had any history of the following conditions?*

☐Head trauma ☐Brain infections ☐Seizures ☐Staring spells ☐Stroke ☐ADHD

☐Anxiety ☐Depression ☐Motion/Car sickness ☐ Learning difficulties ☐Tics

☐Fainting spells ☐Dizziness ☐Fainting spells/Syncope ☐ Patches of brown/red/pale skin

☐Low or High muscle tone ☐Autism ☐ Tremor ☐ Numbness

Other neurologic condition/Details regarding any of the above conditions: _____

_____

Concussion History: Has your child ever been diagnosed with concussion? ☐ NO

☐ Yes – How many times? ____ At what age/s? _____

Was there ever loss of consciousness with a concussion injury? ☐ NO ☐ Yes

We will go over these concussions in detail during the appointment. Please be prepared to supply details of each concussion occurrence, testing & follow up done.

Counseling / Psychiatric: Has your child ever been seen by a counselor, psychologist or psychiatrist? ☐ No

☐ Yes – Name of provider _____

Original concerns: _____

-Was the experience beneficial? ☐ Yes ☐ No _____

-Is your child still being seen this provider ☐ Yes ☐ No

-Have you, as a parent, or a health care provider ever been concerned about the patient in regards to any of the following symptoms or conditions?

☐ Anxiety ☐ Worry ☐ Depression ☐ Suicide ideation

☐ Extreme shyness ☐ Sleeplessness ☐ Obsessive Compulsive ☐ Oppositional Defiant Disorder

☐ Conduct Disorder ☐ Substance abuse ☐ Cutting ☐ Bipolar ☐ ADHD ☐ Eating disorder

☐ In trouble at School or with the Law

Other psychological concerns _____

11. Social History & Habits:

a. *Who lives in the same house as the patient? If 2 households, list everyone in each household .*

Name	Age	Relationship to Patient

b. Is this child adopted? ☐ No ☐ Yes – at what age?_____ ☐ Foster Child

c. Are both parents involved in this child's daily life? ☐ Yes ☐ NO (WHO IS NOT INVOLVED? Mom / Dad)

d. Any of these changes in child's life (in the last 1-2 yrs)? ☐ Parent separation ☐ Move ☐ Custody change ☐ Family members leaving the home ☐ Significant illness/death

e. Other stressors at home? _____

f. Mother's occupation:_____ Father's occupation: _____

12. SCHOOL : School Name _____ Current Grade _____

Address _____

School Nurse _____ Phone Number _____ Fax#_____

Special Services at school (please circle): OT PT Speech Special Ed IEP 504 Plan

Class Size (Please circle): Regular 15:1:1 12:1:1 8:1:1 Homeschooled Other _____

Has your child had psychoeducational or neuropsychological testing? If yes, when & where?

_____

What was the outcome of the testing?_____

How many days of school have been missed the most recent school year specifically related to headache?

_____full days missed _____ Part days/In late _____ Sent home ill with headache

Is your child currently participating fully in their usual gym class and sports?

☐Yes ☐ No → Please explain: _____

How have grades been since the headaches began or increased in frequency?

☐Unchanged/Typical for this child ☐ Worsened ☐ Improved ☐ Failing

Most recent grades have been : (circle all that apply) A / B / C / D / F

13. Family Medical History: *Please check the box if **ANY family members** have any of the following conditions and list the person's relationship to the patient next to the problem.*

Migraines_____ ADHD _____

Headaches of any type_____ Tic's/Tourette's _____

Motion sickness _____ Syncope/Fainting_____

Seizures _____ Degenerative disease _____

Developmental Delay _____ Mental retardation _____

Learning disabilities_____ Brain Tumors _____

Autism _____ Stroke _____

Early death (before age 35) _____ Bleeding/Clotting disorder _____

Anxiety _____ Depression _____

Bipolar _____ Schizophrenia _____

OCD _____ ODD/Conduct Disorder _____

Form Completed by _____ Relation to patient _____

Date completed _____

HEADACHE DIARY Name_____ Date of Birth _____ / _____ / _____

Date							
Time Headache Began							
What was going on when headache began? (in class, sleeping..)							
Any **Warning Signs** that headache was coming on soon?							
Part of Head with Pain (forehead, left side…)							
Type of Pain (squeezing, throbbing, pressure…)							
Intensity of Pain (circle the number that best describes pain: 0=No pain 10= extremely severe)	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Other Symptoms (nausea, vomiting, sensitive to light, numbness…)							
Treatment (Medication or other things done to lessen the pain or make headache go away)							
How did the headache affect usual routine? (went home from schoo l early, stayed in class anyway, missed event…)							
Hours of Sleep the Night Before the Headache							
Meals missed the day of headache?							
Anything exciting or stressful? (Tests, arguments, party…)							
How long did the headache last? What helped the most?							