

Follow-Up Headache Questionnaire

Patient

Today's Date: _____

Previous Visit: _____

1) Overall: how have your headaches been since last visit? Describe details if appropriate:

- Gone
- Better; How? Fewer; How many? _____
- Less severe; how? _____
- Shorter; how short now? _____
- Less associated symptoms _____
- Same
- Worse; How? _____

2) Any problems with the medications? No Yes: What?

3) Any new problems with headaches? No Yes: What?

4) Any ER visits or hospitalizations due to headaches since last visit? No Yes

5) Taking any new medications or alternative treatments? No Yes: What?

F/U HA 03-07

