Patient:_____ Date:_____

Gilbert Headache Questionnaire

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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 your 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 scan, injections, etc.)
☐	☐	28	Have you used any previous headache medication? List all medications on the back of this form.
YES	NO		

arrows must line up

Ptd. in USA 2 HQ-83