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 ______________________