

THE HAMILTON-VEALE

HEADACHE QUESTIONNAIRE

AGE THAT HEADACHES FIRST BEGAN _____

DESCRIBE UNDER WHAT CIRCUMSTANCES
HEADACHES FIRST STARTED _____

IS THERE A HISTORY OF INJURY e.g. MOTOR CAR ACCIDENT?

YES ☐

NO ☐

IS THERE A FAMILY HISTORY OF HEADACHES?

YES ☐

NO ☐

ON THESE DIAGRAMS OF THE HEAD MARK
THE SITE OF PAIN



MARK WITH AN ARROW WHERE THE
HEADACHE SPREADS TO

NATURE OF THE HEADACHE (tick appropriate square)

DEPTH	SEVERITY	FEELING	SPECIAL FEELINGS	TIME SEQUENCE
Deep ache <input type="checkbox"/>	Mild <input type="checkbox"/>	Throbbing <input type="checkbox"/>	Tight band around head <input type="checkbox"/>	Continuous <input type="checkbox"/>
Near surface <input type="checkbox"/>	Moderate <input type="checkbox"/>	Burning <input type="checkbox"/>	Weight on top of head <input type="checkbox"/>	Comes and goes <input type="checkbox"/>
	Severe <input type="checkbox"/>	Dull ache <input type="checkbox"/>	Pain behind eye <input type="checkbox"/>	Steady but builds up <input type="checkbox"/>
	Extreme <input type="checkbox"/>	Knife-like <input type="checkbox"/>	Eye balls dragging out <input type="checkbox"/>	Short time only <input type="checkbox"/>
			Neck ache <input type="checkbox"/>	

DOES ANYTHING
HERALD THE ONSET
OF YOUR HEADACHE? YES ☐
NO ☐

IF YES
WHAT IS IT? ➤

YOUR VISION
Spots before eyes ☐
A veil over eyes ☐
Blurring ☐
Double vision ☐

➤ NUMBNESS &
TINGLING OF BODY ☐
AN ACHING NECK ☐
OTHER (explain) _____

FREQUENCY
OF HEADACHE

Every day ☐
Once/week ☐
Once/month ☐
Other ☐

HOW LONG DOES
YOUR HEADACHE
USUALLY LAST?

10 minutes ☐
1-2 hours ☐
4-6 hours ☐
Days ☐
Weeks ☐
Other ☐

ONSET OF
HEADACHE

Abrupt ☐
Gradual ☐

TIME OF
DAY

Wake up with it ☐
Starts in morning ☐
Starts during day ☐
Starts at night ☐
Starts any time ☐

Time of day
Morning ☐ Worse ☐ Better ☐
Afternoon ☐
Evening ☐

FACTORS THAT BRING ON HEADACHE

Stress ☐
Tiredness ☐
Alcohol ☐
Colds ☐
Worry ☐
Exercise ☐
Reading ☐
Bright lights ☐
Hunger ☐
Eye strain e.g. TV ☐
The city ☐
Chilly draughts ☐
Neck movements ☐
or jarring ☐

FACTORS THAT AGGRAVATE HEADACHE

Exercise ☐
Straining at stool ☐
Coughing ☐
Standing ☐
Bending forward ☐
Car travel ☐
Neck troubles ☐
Bright lights ☐
Chewing ☐
Hunger ☐
Reading ☐
Worry and stress ☐

FACTORS THAT RELIEVE HEADACHE

Water ☐
Quietness ☐
Sleeping ☐
Alcohol ☐
Fresh air ☐
Dark room ☐
Food ☐
Good news ☐
Medication ☐

ASSOCIATED PROBLEMS

Double vision ☐
Tender temples ☐
Nausea ☐
Vomiting ☐
Fever ☐
Runny nose ☐
Tingling teeth ☐
Swelling around eyes ☐
Giddiness ☐
Stress ☐
Behavioural changes e.g. irritable ☐
Blood pressure ☐

OTHER ASSOCIATIONS

Menstruation ☐
Contraceptive pill ☐
Allergies ☐
Depression ☐
Following colds ☐
Certain foods ☐
Caffeine intake ☐
Neck jarring ☐
Sleep troubles ☐

G.P.'s NAME _____

YOUR GENERAL HEALTH IS

Good ☐
Poor ☐
Variable ☐

ARE YOU ON MEDICATION?

Yes ☐ No ☐ IF YES _____

Name medications _____

Your Blood Pressure is _____

THE HAMILTON-VEALE

HEADACHE DIARY

PATIENT NAME _____

REFERENCE No. _____

[illegible]

ADDITIONAL COMMENTS:

PRACTICE NAME & DETAILS