Minneapolis Clinic of Neurology

Pediatric Neurology Information-Headaches
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Patient Name_____ DOB_____

Please answer the following questions to the best of your knowledge. This information will assist us in evaluation of your child's headaches. Please also complete the attached pedMIDAS scale.

1. How long have the headaches been present? _____
2. How often do they occur? (e.g. how many times per week or per month?) _____
3. Where on the head are they located?_____
4. How long do they usually last?_____
5. How do they feel? (e.g. pounding, throbbing, pressure, squeezing, etc.)_____
6. Does the child experience any type of sensation that is not head pain prior to a headache starting? YES NO
   A. If yes, describe the sensation _____
8. Does sleep help the headache? YES NO
   A. If no, what helps the headache?_____
9. Which medications, if any, has your child tried for headaches (both over-the-counter and prescription)?

_____

_____

10. Has the child ever gone to bed without a headache and woken up from sleep because of a new headache? YES NO
    A. If yes, how often does this happen? _____
    B. Is this a new problem or has this occurred since the headaches started? NEW OLD
11. Is the headache worse when laying down, standing up or neither?_____
12. For girls: If the child has started her periods, do the headaches become worse during a period? YES NO
13. Which family member(s), if any, have now or in the past had severe, recurrent headaches?_____
14. Check correct response:

| | Yes | No |
|---|---|---|
| a. child missed school due to headache | ___ | ___ |
| b. school work has changed recently | ___ | ___ |
| c. child stops playing or goes to bed voluntarily when they have a headache | ___ | ___ |
| d. child has had seizure or convulsion | ___ | ___ |
| e. child has had a concussion or skull fracture | ___ | ___ |
| f. child has problems with her/his mood | ___ | ___ |
| g. child has now or had bedwetting problem | ___ | ___ |
| h. headaches occur in morning upon awakening | ___ | ___ |
| i. headaches always occur at the same time | ___ | ___ |

15. Please check column best describing the effect that food has on the child's headaches:

| Food | Increased | Decreased | No Change | Don't Know |
|---|---|---|---|---|
| Hot dogs | | | | |
| Cheese | | | | |
| Caffeine | | | | |
| Milk | | | | |
| Chinese food | | | | |
| Chocolate | | | | |
| Sugar | | | | |
| Other: _____ | | | | |

Please continue on other side

16. How often does the child have the following symptoms with her/his headache?

| | Always | Occasional | Rare | Never |
|---|---|---|---|---|
| Blurred vision | | | | |
| Double vision | | | | |
| Loss of vision | | | | |
| Difficulty hearing | | | | |
| Ringing in ear(s) | | | | |
| Dizziness | | | | |
| Passes out | | | | |
| Slurred speech | | | | |
| Difficulty chewing or swallowing food | | | | |
| Nausea | | | | |
| Stomach ache or pain | | | | |
| Vomiting | | | | |
| Difficulty breathing | | | | |
| Racing heartbeat | | | | |
| Numbness/tingling of only one side of body | | | | |
| Weakness of arms or legs on only one side of body | | | | |

17. Please check the column describing the effect upon your child's headaches:

| | Increased | Decreased | No Change | Don't Know |
|---|---|---|---|---|
| Riding in a car | | | | |
| Exercise/gym | | | | |
| Reading | | | | |
| Bright lights | | | | |
| Watching TV | | | | |
| Loud sounds | | | | |
| Tylenol | | | | |
| Ibuprofen (e.g. Advil, Motrin) | | | | |
| Sleep | | | | |
| Vacations | | | | |
| Weekends | | | | |
| School days | | | | |
| Quick movements of the head | | | | |
| Other: _____ | | | | |

18. What does your child normally drink during the day?_____
19. What color is your child's urine most of the time? CLEAR LIGHT YELLOW DARK YELLOW
20. Does your child normally eat breakfast? YES NO
21. Does your child eat leafy green vegetables? YES NO
    A. If no, does your child take a daily multivitamin? YES NO
22. On school days, how many hours does your child sleep, on average?_____
23. Does your child snore? YES NO
    A. If yes, have you ever noticed him/her stop breathing during sleep? YES NO
24. Is your child much more tired than his or her peers during the school day? YES NO