INSTITUTE OF NEUROLOGY

HEADACHE AND FACIAL PAIN QUESTIONNAIRE

Date	/ /

SECTION 1: PERSONAL DETAILS

Surname		Date of Birth	/ /
First Name		Age	
Hospital Number			
Sex		Male ☐ Female ☐	
Handedness		Right ☐ Left ☐ Ambidextrous ☐	
Marital status		Single ☐ Married ☐ Divorced/Separated ☐ Living with Partner ☐ Widowed ☐	
Occupation			
If not working, tick the appropriate box:		Housewife ☐ Student ☐ Unemployed ☐ Retired ☐	

SECTION 2: HEADACHE/ FACIAL PAIN

Please repeat this section for each different type of headache/ facial pain

A. **Onset**

1. Age of onset of pain	
2. Duration (years)	
3. Was there any initial trigger?	Yes ▫ No ▫
4. Precipitant triggers	▫ Head injury ▫ Facial injury ▫ Neck injury ▫ Operation ▫ Back trauma ▫ Viral infection ▫ Illness ▫ Oral surgery ▫ Episode of extreme stress ▫ Airplane flight ▫ Pregnancy ▫ Other ……..
4. If the answer to Question 3 was 'Yes' then describe the trigger and state the time of onset of the trigger in relation to the onset of the headache attacks	Trigger: …… …….. Onset of Trigger: …….. ……..

B. **Side and site**

1.	On which side of the head do you experience the attacks?	Right …….% Left …….% Alternates …….% Bilateral …….%	▫ ▫ ▫ ▫
2.	If the attacks have occurred on both sides, then has the pain shifted sides during an attack, in different attacks but in the same bout or in different bouts?	Side shifted during a single attack Side shifted in different attacks during same bout Side shifted in different bouts No	▫▫ ▫▫
3.	Tick the regions over which the pain is felt	Peri-orbital ▫ Retro-orbital ▫ Frontal ▫ Temple ▫ Parietal ▫ Occipital ▫ Vertex ▫ Nasal ▫ Cheek ▫ Upper teeth ▫ Lower teeth ▫	Palate ▫ Floor of mouth ▫ Jaw ▫ Ear ▫ Chin ▫ Neck ▫ V2 ▫ V3 ▫ Shoulder ▫ Other (describe below) ▫

C.Severity and characteristics of pain

1.	Usual severity of the pain	VRS:	
2.	Intensity range (Min-Max)	VRS:	
3.	Which of these descriptions of pain apply to your attacks?	Aching ▫ Boring ▫ Shooting ▫ Electric ▫ Burning ▫ Pins and needls ▫ Dull ▫ Pressure feeling ▫	Stabbing ▫ Tearing ▫ Tightening ▫ Throbbing ▫ Sharp ▫ Sudden ▫ Gradual ▫ Others (describe below) ▫

D. Duration and frequency

1.	How long does the ***average*** attack last for?	Seconds/mins/hours:
2.	Duration range of an attack (Min-Max)	Seconds/mins/hours:
3.	What is the ***average*** number of headache attacks that occur per day?	
4.	Frequency range of attacks (Min-Max)	Day/week/month:

E. Timing

1.	Are the attacks more likely to occur when awake or during sleep? (Tick one only)	Awake Sleep Both	▫▫ ▫
2.	Which is the average percentage?	Awake: ……. %	Sleep: ……%

3.	Do the attacks occur at a predictable time or randomly?	Predictable ▫ Random ▫ If predictable, specify the times …….
4.	Is there any time in which the attacks get **worse**?	Waking up ▫ Mid-morning ▫ Mid-day ▫ Afternoon ▫ Evening ▫ Overnight ▫▫ No difference ▫

F. Trigeminal autonomic cephalgic characteristics

1.	Number of attacks per bout		
2.	***Average*** duration of bouts		
3.	Range of duration of a bout (Min-Max)		
4.	Number of bouts per year		
5.	When was the last bout?		
6.	Are your bouts more likely to occur in any particular month/ months?	▫ Yes ▫ No	
7.	If the answer to Question 6 is yes, then during which months are the bouts most likely to occur?	▫ January ▫ February ▫ March ▫ April ▫ May ▫ June	▫ July ▫ August ▫ September ▫ October ▫ November ▫ December
8.	Over the last 12 months, have you had a pain free period lasting more than one continuous month? **(Remission period)**	▫ Yes ▫ No	
9.	***Average*** duration of remission period		
10.	Range of duration of remission period (Min-Max)		

G. Associated symptoms

1.	**CRANIAL AUTONOMIC FEATURES**	Drooping of the eyelid ▫ Same side ▫ Opposite side ▫ Both sides ▫ Miosis ▫ Same side ▫ Opposite side ▫ Both sides ▫ Swelling of the eyelid ▫ Same side ▫ Opposite side ▫ Both sides ▫ Redness of the eye ▫ Same side ▫ Opposite side ▫ Both sides ▫ Watering of the eye ▫ Same side ▫ Opposite side ▫ Both sides ▫ Blockage of the nose ▫ Same side ▫ Opposite side ▫ Both sides ▫ Running of the nose ▫ Same side ▫ Opposite side ▫ Both sides ▫ Facial sweating ▫ Same side ▫ Opposite side ▫ Both sides ▫ Flushing of the face ▫ Same side ▫ Opposite side ▫ Both sides ▫ Fullness in the ears ▫ Same side ▫ Opposite side ▫ Both sides ▫ Swelling of mouth/face ▫ Same side ▫ Opposite side ▫ Both sides ▫ Dyspnoea/hyperventilation Yes ▫ No ▫ **Attacks without autonomics?** ▫ **Restless/ Agitation** Yes ▫ No (Still) ▫
2.	**MIGRAINOUS FEATURES**	Nausea (feel sick) ▫ Everytime ▫ Sometimes ▫ Vomiting ▫ Everytime ▫ Sometimes ▫ Sensitivity to light ▫ Same side ▫ Opposite side ▫ Both sides ▫ Sensitivity to sounds ▫ Same side ▫ Opposite side ▫ Both sides ▫ Sensitivity to smells ▫ Same side ▫ Opposite side ▫ Both sides ▫ Motion sensivity ▫ Everytime ▫ Sometimes ▫ Vertigo ▫ Everytime ▫ Sometimes ▫
3.	**AURA** **- ≥5 min and ≤60 min** **-Gradual onset and offset**	**YES** ▫ **NO** ▫ VISUAL SYMPTOMS such as blurred vision, flashing lights, zig-zag lines dark spots in one visual field ▫ SENSORY SYMPTOMS such as tingling or numbness ▫ SPEECH SYMPTOMS (dysphasia/dysarthria) ▫ WEAKNESS in one or more limbs ▫ BASILAR: (diplopia, vertigo, tinnitus, ataxia bilateral paraesthesia, decreased level of consciousness) Total number of attacks with headache ..... Total number of attacks without headache ..... Duration of aura .....

8.	**ALLODYNIA**: areas of hyperalgesia	**YES** **NO** Ipsilateral Contralateral Bilateral	▫ ▫ ▫ ▫ ▫

H. Characteristics of the attacks

1.	**TRIGGERED/SPONTANEOUS** attacks	Cutaneous triggered ▫ Only spontaneous ▫ Both ▫▫ Non cutaneous triggers
2.	If you have **both**, please quantify the percentage of each	Triggered …….. **%** Spontaneous …… **%**
3	Relation between cutaneous triggers and side of pain	Ipsilateral triggers ▫ Other triggers ▫▫ Contralateral triggers ▫▫ Bilateral triggers Extra-trigeminal triggers

I. Trigger and relieving factors (if only spontaneous, don't tick the provoking)

	FACTORS	PROVOKING	RELIEVING
1.	Light touch	▫	▫
2.	Pressure on the face	▫	▫
3.	Squeezing eyelids	▫	▫
4.	Chewing/ eating	▫	▫
5.	Swallowing	▫	▫
6.	Wind	▫	▫
7.	Washing face	▫	▫
8.	Brushing teeth	▫	▫
9.	Moving	▫	▫
10	Talking	▫	▫
11	Opening wide/yawning	▫	▫
12	Washing or brushing hair	▫	▫
13	Exercise	▫	▫
14	Light	▫	▫
15	Shower	▫	▫
16	Shaving	▫	▫
17	Blowing nose	▫	▫
18	Neck rotation towards symptomatic side	▫	▫
19	Neck extension/ flexion	▫	▫
20	Food: cold/ hot/ sweet	▫	▫

21	Alcohol	▫	▫
22	Smoking	▫	▫
23	Cough and/or sneeze	▫	▫
24	Strong smells (eg perfumes, petrol fumes)	▫	▫
25	Relaxation	▫	▫
26	Sleep	▫	▫
27	Recreations	▫	▫
28	Others (Please specify below)	▫	▫
29	None	▫	▫

J. Refractory period

1.	Could you have a triggered attack immediately after cessation of the previous one?	No (refractory period) Yes (no refractory period) No triggers	▫ ▫ ▫
2.	If not, which is the duration of the refractory period?	Seconds/minutes:	

K. Features immediately after a headache/ facial pain attack

1.	Do you get any of the following **symptoms immediately after the headache/facial pain** attack is over?	Irritability/ moody Feeling of being energetic/ well-being Feeling hungry Loss of appetite Passing urine frequently Diarrhoea Constipation Tiredness Yawning None of the above Go to section 3 if you get **none** of the above symptoms	▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	Drowsiness Difficulty concentrating Abnormal sensations: burning, numbness, tingling or tenderness Other (describe below)	▫ ▫ ▫ ▫
2.	Duration of these symptoms				
3.	Do you get these symptoms after each or most headache attacks?	Each ▫	Most ▫	Seldom ▫	

L. Developmental migraine markers

Have you ever had any of the following?	▫ Motion sickness ▫ Recurrent abdominal pain ▫ Cycling vomiting ▫ Vertigo ▫ Hangovers

M. Natural history

1	EPISODIC	▫
2	EPISODIC to CHRONIC	▫ Age at chronification ……
3	CHRONIC from onset	▫
4	CHRONIC from onset to REMISSION	▫ Duration of the remission period ……..
5	CHRONIC to EPISODIC	▫
6	EPISODIC to CHRONIC to EPISODIC	▫
7	CHRONIC to EPISODIC to CHRONIC	▫

SECTION 3: INTERICTAL PAIN

Have you got any background pain between the headache/facial pain attacks?

YES ▫ NO ▫ (please continue to Section 4)

A. Onset

1.	Age of onset of interictal pain	
2.	Temporal GAP between the main pain onset and interictal pain onset:	Weeks/ Months/ Years:
3.	Was there any interictal pain initial trigger?	Yes ▫ No ▫
4.	Precipitant triggers	▫ Head injury ▫ Facial injury ▫ Neck injury ▫ Operation ▫ Back trauma ▫ Viral infection ▫ Illness ▫ Oral surgery ▫ Episode of extreme stress ▫ Airplane flight ▫ Pregnancy ▫ Prophylactic medication ▫ Medication overuse ▫ Other ……..
5.	If the answer to Question 3 was 'Yes' then describe the trigger and state the time of onset of the trigger in relation to the onset of the interictal pain	Trigger: …… …….. Onset of Trigger: …….. ……..

B. Side and site

1.	Side relation between the interictal pain and the headache/ facial pain	Ipsilateral ▫ Contralateral ▫ Bilateral ▫			
2.	Tick the regions over which the pain is felt	Peri orbital ▫ Retro orbital ▫ Front ▫ Temple ▫ Parietal ▫ Vertex ▫ Occipital ▫ Nose ▫ Cheek ▫ Upper teeth ▫ Lower teeth ▫		Palate ▫ Floor of mouth ▫ Jaw ▫ Ear ▫ Chin ▫ Neck Shoulder Other (describe below)	

C. Severity and characteristics of the pain

1.	The **usual** severity of interictal pain	VRS:			
2.	Severity range (Min-Max)	VRS:			
3.	Which of these **descriptions of pain** apply to your interictal pain? (You can tick more than one choice).	Aching ▫ Boring ▫ Shooting ▫ Electric ▫ Burning ▫ Pins and needls ▫ Burning ▫ Dull ▫ Pressure feeling ▫ Others (describe below) ▫		Stabbing ▫ Tearing ▫ Tightening ▫ Throbbing ▫ Sharp ▫ **Sudden** ▫ **Gradual** ▫	

D. Duration and frequency

1.	***Average*** duration of the pain per day	
2.	Range of duration per day (Min-Max)	
3.	Constant all the time	Yes ▫ No ▫
4.	Background pain only after an attack	Yes ▫ No ▫
5.	**Number of days** of interictal pain **per month**	
6.	**Number of months** of interictal pain **per year**	

E. Associated symptoms

NO ▫

YES ▫ If yes, please specify:

.....
.....
.....

F. Trigger and relieving factors

	FACTORS	PROVOKING	RELIEVING
1	Headache/ facial pain attacks	▫	
2	Stress	▫	▫
3	Neck movements	▫	▫
4	Fasting (missing meals)	▫	▫
5	Alcohol	▫	▫
6	Smoking	▫	▫
7	Sleep deprivation/ excess	▫	▫
8	Coffee	▫	▫
9	Tiredness	▫	▫
10	Change in weather	▫	▫
11	Cough and/or sneeze	▫	▫
12	Loud sounds	▫	▫
13	Strong smells (eg perfumes, petrol fumes)	▫	▫
14	Menstruation	▫	▫
15	Physical exertion	▫	▫
16	Relaxation from stress	▫	▫
17	Sleep	▫	▫
18	Recreations (Take your mind off it)	▫	▫
19	Others (Please specify below)	▫	▫
20	None ▫		

SECTION 4: INVESTIGATIONS

A. Examination

1.	Neurological examination performed	Yes ▫ Date (/ /) No ▫
2.	Result	

B. Neuroimaging/ pituitary profile

INVESTIGATION		DATE	RESULT
CT Scan	▫		

MRI Scan	▫		▫ Normal ▫ Pituitary abnormality • Type: ▫ Abnormal vascular loop: • Artery: ..... • Vein: ..... ▫ Ipsilateral ▫ Contralateral ▫ Bilateral ▫ Other posterior fossa abnormalities • Type: ▫ Other findings
Follow-up MRI Scan	▫		
Cerebral angiography	▫		
Pituitary blood profile	▫		▫ Normal ▫ Abnormality detected : .....

SECTION 5: TREATMENTS

RESPONSE SCALE:

No response (0): no change in headache frequency or severity

Mild (1): ≤ 30%: there is only a slight reduction in frequency and/or severity of attacks

Moderate (2): 31-60%: there is a moderate reduction in headache frequency and/or severity

Good (3): 61-90%: marked reduction in headache frequency and/or severity

Excellent (4): 91-100%: The pain is completely or almost completely gone

Worsen (5)

Worsen a different type of headache (6)

A. Medications to date

MEDICATION		Dose (S=standard)	Year tried	Duration of the trial	Effects (0-6)	Type of attacks (spontan=1, triggered=2, both=3, any effect=0)	Side effects	Stopped due to side effects
ABORTIVES								
Sumatriptan injections (Imigran injections)	▫							
Oxygen (give flow rate and duration taken during attack)	▫							
Sumatriptan nasal spray (Imigran nasal spray)	▫							

Lignocaine nasal spray (lidocaine, xylocaine)	▫							
Indomethacin	▫							
Rizatriptan (Maxalt)	▫							
Ergotamine suppository (Cafergot)	▫							
LIGNOCAINE PATCH	▫							
LIGNOCAINE I.V.	▫							
DHE I.V. 1	▫							
STEROIDS I.V.	▫							
PREVENTIVES								
Verapamil	▫							
Topiramate	▫							
Gabapentin	▫							
Pregabalin	▫							
Lithium	▫							
Methysergide	▫							
Sodium valproate	▫							
Melatonin	▫							
Mexilitine	▫							
Lamotrigine	▫							
Carbamazepine	▫							
Oxcabazepine	▫							
Baclofen	▫							
Duloxetine	▫							
Phenytoin	▫							
Propanolol	▫							
Lacosamide	▫							
Steroids P.O.	▫							
Others (please specify)	▫							
	▫							
	▫							
TRANSITIONALS	▫							
GON block	▫							
Multiple cranial nerve blocks	▫							
Botolinum toxin injection	▫							
	▫							

	▫							
	▫							
	▫							

B. Surgical procedures

Please repeat this section for each different type of surgical procedure done

1.	Have you had any operations or surgical procedures for your headache/ facial pain?	Yes ▫ No ▫
2.	If yes, please list the operations or procedures (including the year of the procedure)	…… … …… … …… …
3	Effect of procedure	**Improvement** ▫ %: After how many times: For how long: Reduction of: number of attacks, intensity, duration Background pain: **Worsening** ▫ After how many times: For how long: Increase of: number of attacks, intensity, duration: Background pain: **Start of another different headache** ▫ **No change** ▫ Issues related to the procedure: Follow-up:

C. Alternative treatments

None: ▫

TYPE OF TREATMENT		**Year tried**	**Effects (0-4)**	**Duration of the effects**
Acupuncture	▫			
Chiropractic	▫			
Herbal treatments	▫			
Homeopathy	▫			
Hypnosis	▫			
Osteopathy	▫			

Reflexology	▫			
Spiritual healing	▫			
Other (please specify)	▫			

SECTION 6: DIAGNOSIS

1. How long after the onset of these headaches was the diagnosis made?				
2. Who made the diagnosis of these headaches?				
3. Please indicate which of the following doctors you have saw **BEFORE** the diagnosis was made	PRACTITIONER	NUMBER SEEN	DIAGNOSIS OFFERRED	TREATMENT GIVEN
	GP ▫			
	Neurologist ▫			
	Dentist ▫			
	ENT Specialist ▫			
	Optician ▫			
	Ophthalmologist ▫			
	Others (Please specify) ▫			

PART 3: OTHER HEADACHES

MIGRAINE

AGE OF ONSET:

SIDE AND SITE:

1.	side of the headache:	Right side only ▫ Left side only ▫ Predominantly on right side but some on left side ▫ Predominantly on left side but some on right side ▫ Right and left sides equally ▫ Bilateral ▫			
2.	Tick the regions over which the pain is felt.	Peri-orbital Retro-orbital Front Temple Parietal Vertex Occipital Nose Cheek Upper teeth Lower teeth	▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	Palate Floor of mouth Jaw Ear Chin Neck Shoulder Other (describe below)	▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫

SEVERITY AND CHARACTERISTICS OF PAIN

1.	Which is the **usual** severity of the pain?	VRS:			
2.	**Range** of intensity of headache (Min-Max)	VRS:			
3.	**Quality** of pain	Aching	▫	Stabbing	▫
		Boring	▫	Tearing	▫
		Shooting	▫	Tightening	▫
		Electric	▫	Throbbing	▫
		Burning	▫	Sharp	▫
		Pins and needls	▫		
		Burning	▫		
		Dull	▫		
		Pressure feeling	▫		
		Others (describe below)	▫		

DURATION AND FREQUENCY

1.	***Average*** attack duration	Hours:
2.	Average number of days with headache **a month**	
3.	If chronic pattern, **age/year of transforming**:	

ASSOCIATED SYMPTOMS

1.	**CRANIAL AUTONOMIC FEATURES**	Drooping of the eyelid	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Swelling of the eyelid	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Redness of the eye	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Watering of the eye	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Itchy or gritty eye	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Blockage of the nose	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Running of the nose	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Facial sweating	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Flushing of the face	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Fullness in the ears	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Swelling mouth/face	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Restless/Agitation		Yes	▫	No	▫	
2.	**MIGRAINOUS FEATURES**	Nausea (feel sick)	▫	Everytime	▫	Sometimes	▫	
		Vomiting	▫	Everytime	▫	Sometimes	▫	
		Sensitivity to light	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Sensitivity to sounds	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Sensitivity to smells	▫	Same side	▫	Opposite side	▫	Both sides
		Motion sensivity	▫	Everytime	▫	Sometimes	▫	
		Vertigo	▫	Everytime	▫	Sometimes	▫	
		Tinnitus (Ringing in ears)	▫	Same side	▫	Opposite side	▫	Both sides ▫
		Poor salivation	▫	Everytime	▫	Sometimes	▫	
		Fatigue	▫	Everytime	▫	Sometimes	▫	
		Light…..	▫	Everytime	▫	Sometimes	▫	

3.	**AURA** - **With interictal pain start before or during the aura** - **≥5 min and ≤60 min** **-Gradual onset and remission**	**No** ▫ **Yes** ▫ VISUAL SYMPTOMS such as blurred vision, flashing lights, zig-zag lines dark spots in one visual field ▫ SENSORY SYMPTOMS such as tingling or numbness ▫ SPEECH SYMPTOMS (dysphasia/disartria) ▫ WEAKNESS in one or more limbs ▫ BASILAR: (diplopia-vertigo-tinnitus-ataxia-bilat parestesia-decrease level of consciousness) ▫ Total number of attacks with headache ..... Total number of attacks without headache ..... Duration of aura .....
4.	**ALLODYNIA**: areas of hyperalgesia	YES ▫ NO ▫ Ipsilateral ▫ Controlateral ▫ Bilateral ▫

MEDICATION OVERUSE

NO: ▫

1	Intake of **ANALGESIC** drugs for ≥15 days/ month on a regular basis for >3 months	Yes ▫	No ▫
2	Intake of **TRIPTANS** for ≥10 days/month on a regular basis for >3 months	Yes ▫	No ▫
3	Intake of any **OPIOIDS (Codein, Tramadol, Morphine)** for ≥10 days/month on a regular basis for >3 months	Yes ▫	No ▫
4	Intake of **ERGOTAMINE** for ≥10 days/ month on a regular basis for >3 months	Yes ▫	No ▫
5	Intake of **COMBINATION drugs** for ≥10 days/month on a regular basis for >3 months	Yes ▫	No ▫
6	Year of overuse		

DIAGNOSIS (IHS criteria):

- EPISODIC MO ▫

- CHRONIC MO ▫
- MA ▫
- HEMIPLEGIC MIGRAINE ▫
- Other ▫

SECTION 3: LIFESTYLE FACTORS

PAST MEDICAL HISTORY

1.	Have you had any of the following illnesses (underline the illness that you have or have had)	Depression, Anxiety, Mental disorders, Stroke, Epilepsy, Heart murmurs, High blood pressure, Angina, Heart attack, Rheumatic fever, Asthma, Bronchitis, Emphysema, Pneumonia, Tuberculosis, Jaundice, Hepatitis, Gall stones, Persistent diarrhoea, Rectal bleeding, Colitis, Kidney stones, Urinary tract infection, Arthritis, Diabetes, Thyroid disorders, Blood disorders, Cancer.
2.	Do you have any other illness not already mentioned above? (Please specify)	…… …… …… …… …… …… ……
3.	List the operations that you have had for any conditions other than cluster headaches.	…… …… …… …… …… ……

FAMILY HISTORY

A. HEADACHES AND OTHER MEDICAL ISSUES

1.	Does any member of your family have your type of headache?	Yes ▫ No ▫
2.	Does any member of your family have migraine?	Yes ▫ No ▫
3.	Does any member of your family have any other headaches?	Yes ▫ No ▫
4.	**Family history for other diseases?**	Yes ▫ No ▫

SOCIAL FACTORS

A. ALCOHOL INTAKE

1.	Do you drink alcohol?	Yes ▫ No ▫
2.	Age of onset	
3.	What is you average alcohol consumption per week? (1 UNIT= 1/2pint, 1glass of wine, 1 misure of spirit)	Pints of beer …… Measures of spirits …… Glasses of wine ……
4.	Did you stop drinking alcohol?	Yes ▫ No ▫ Year:
5.	Did you stop drinking alcohol due to your headaches?	Yes ▫ No ▫
6.	Any relation between alcohol intake and the pain?	

B. SMOKING

1.	Do you smoke cigarettes/cigars/tobacco?	Yes ▫ No ▫
2.	Age of onset	
3.	Number of cigarettes per day	
4.	If ex-smoker, when did you give up smoking?	……. Not given up ▫
5.	Did you stop smoking due to your headaches?	Yes ▫ No ▫ Not given up ▫
6.	Any relation between smoke and the pain?	