S30r1 Headache Event Neurologist

Ad Hoc Event ID _____

Visit Date (yyyy/mm/dd): _____

Correction:
- ☐ Yes
- ☐ No

Part A. Headache in Patients with Sickle Cell: Screening for Acute Headache

1. Does your child have a headache now or at any time during the past 7 days? If Yes, complete Items 2-4. If No, skip to Item 5.
- ☐ Yes
- ☐ No

2. Has she/he had similar headaches before?
- ☐ Yes
- ☐ No

3. How does your child describe the headache?
- ☐ Mild, not interfering with activity
- ☐ Moderate, interfering with activity somewhat*
- ☐ SEVERE, UNABLE TO FUNCTION**
- ☐ Other

3A. If Other, describe: _____

4. Did or does your child have a fever or other symptoms with the headache?
- ☐ Yes**
- ☐ No

4A. If Yes, describe other symptoms: _____

Screening for Recurrent Headache

5. Does your child have recurring headaches?
- ☐ No
- ☐ Yes, once in awhile (< 1 per month)*
- ☐ Yes, regularly (1-4 per month)*
- ☐ Yes, frequently (> 1 per week)*

6. Has your child ever had a very severe headache, which prevented him/her from participating in normal activities, or which caused you to take him/her to the doctor or emergency room?
- ☐ Yes
- ☐ No

If both Items 5 and 6 are No, skip to Part C.

7. Your child is confused or difficult to wake up during headache.
- ☐ Never
- ☐ Once in awhile*
- ☐ WITH MOST HEADACHES**

8. Your child complains of a stiff neck or neck pain during headache.
- ☐ Never
- ☐ Once in awhile*
- ☐ WITH MOST HEADACHES**

9. Your child has a neurological symptom during or after a headache.
- ☐ Never
- ☐ Once in awhile*
- ☐ WITH MOST HEADACHES**

9A. Specify the neurological symptom that occurred - could not see:
- ☐ Yes
- ☐ No

9B. Specify the neurological symptom that occurred - became dizzy (as though the room was spinning):
- ☐ Yes
- ☐ No

9C. Specify the neurological symptom that occurred - could not speak or could not comprehend what was spoken:
- ☐ Yes
- ☐ No

9D. Specify the neurological symptom that occurred - paralysis or inability to move one side of the body or a part of the body:
- ☐ Yes
- ☐ No

9E. Specify the neurological symptom that occurred - unsteady gait:
- ☐ Yes
- ☐ No

9F. Specify the neurological symptom that occurred - other:
- ☐ Yes
- ☐ No

9F-1. If Other, specify: _____

10. Your child is awakened in the middle of the night by a headache, which was not present at the time he/she went to sleep.
- ☐ Never
- ☐ Once in awhile*
- ☐ WITH MOST HEADACHES**

Part B. Questionnaire for Chronic Headaches in Patients with Sickle Cell Anemia (adapted from UK headache form). Complete this section if the reply to Item 5 in Part A was "Yes".

11. Lifetime headache occurrence: has your child had any headache within the following time periods?
- ☐ Within the last 6 months before the present visit
- ☐ Within the last 12 months before the present visit
- ☐ Within the last 2 years before the present visit
- ☐ None within the last 2 years, but one or more at some time prior to the last 2 years
- ☐ None

12. Headache frequency (on average):
- ☐ > 1 per year, < 1 per month
- ☐ 1-4 per month
- ☐ 2-4 per week
- ☐ 5-7 days per week, with HA-free periods
- ☐ Daily - unremitting, no or few HA-free periods
- ☐ Other pattern of frequency

12A. If "Other pattern of frequency," specify: _____

13. At what age did your child begin to have headaches (xx years)? _____

14. When does headache most typically occur?
- ☐ Upon awakening
- ☐ During daytime at school
- ☐ During afternoon/evening after coming home from school
- ☐ Evening on going to bed
- ☐ No particular time, random times

15. Where is the headache located most typically?
- ☐ Bifrontal or bitemporal
- ☐ Hemicranial
- ☐ Vertex
- ☐ Occipital
- ☐ Non-localized, diffuse

16. Duration of typical headache attack:
- ☐ < = 1 hour
- ☐ > 1 hour and < = 2 hours
- ☐ > 2 hours and < = 4 hours
- ☐ > 4 hours

17. Severity of typical headaches:
- ☐ No interruption of normal life activities
- ☐ Some disruption of normal life activities, but no need to go to bed
- ☐ Complete disruption of normal life activities, needs to go to bed
- ☐ Prevents sleep
- ☐ Awakens patient from sleep

18A. Other symptoms associated with some or most headaches: Nausea or vomiting
- ☐ Yes
- ☐ No

18B. Other symptoms associated with some or most headaches: Excessive sensitivity to light or sound
- ☐ Yes
- ☐ No

18C. Other symptoms associated with some or most headaches: Fatigue, malaise
- ☐ Yes
- ☐ No

18D. Other symptoms associated with some or most headaches: Visual symptoms
- ☐ Yes
- ☐ No

18D-1. If Yes, specify: _____

18E. Other symptoms associated with some or most headaches: Other
- ☐ Yes
- ☐ No

18E-1. If Yes, specify: _____

19. Is medication taken for most headaches?
- ☐ No
- ☐ Yes, daily preventative medication
- ☐ Yes, abortive/rescue medication

19A. When is abortive/rescue medication taken?
- ☐ At headache onset (within 15 minutes)
- ☐ When pain is unbearable

19B. How effective is the abortive/rescue medication?
- ☐ Partial improvement most occasions
- ☐ Complete remission most occasions
- ☐ Little/no improvement most occasions

20. Has the patient tried dietary restrictions to prevent or reduce headache frequency?
- ☐ Yes
- ☐ No

20A. Did dietary modifications help?
- ☐ Yes
- ☐ No

21A. What other life habit modifications, if any, has the patient tried? Improve sleep habits
- ☐ Yes
- ☐ No

21B. What other life habit modifications, if any, has the patient tried? Avoid fasting
- ☐ Yes
- ☐ No

21C. What other life habit modifications, if any, has the patient tried? Behavioral or psychological interventions to reduce psychosocial stressors
- ☐ Yes
- ☐ No

21D. What other life habit modifications, if any, has the patient tried? Other
- ☐ Yes
- ☐ No

22A. What, if any, headache triggers are clearly appreciated by the parent or patient? Sleep deprivation
- ☐ Yes
- ☐ No

22B. What, if any, headache triggers are clearly appreciated by the parent or patient? Psychosocial stress
- ☐ Yes
- ☐ No

22C. What, if any, headache triggers are clearly appreciated by the parent or patient? Intercurrent illness
- ☐ Yes
- ☐ No

22D. What, if any, headache triggers are clearly appreciated by the parent or patient? Specific food exposures
- ☐ Yes
- ☐ No

22E. What, if any, headache triggers are clearly appreciated by the parent or patient? Physical exertion
- ☐ Yes
- ☐ No

22F. What, if any, headache triggers are clearly appreciated by the parent or patient? Riding in a car
- ☐ Yes
- ☐ No

22G. What, if any, headache triggers are clearly appreciated by the parent or patient? Other
- ☐ Yes
- ☐ No

23A. What, if any, history of sleep-related symptoms are present? Snoring or obstructive sleep apnea
- ☐ Yes
- ☐ No

23B. What, if any, history of sleep-related symptoms are present? Fragmented sleep or night-time awakening
- ☐ Yes
- ☐ No

23C. What, if any, history of sleep-related symptoms are present? Difficulty falling asleep
- ☐ Yes
- ☐ No

23D. What, if any, history of sleep-related symptoms are present? Other
- ☐ Yes
- ☐ No

24. Are there other immediate family members (parent, grandparent, aunt, uncle, or sibling) with a history of recurrent headaches?
- ☐ Yes
- ☐ No
- ☐ Don't know

Part C - Summary of Impressions of Headaches: Based on a review of results of Parts A and B, and findings on examination, the study neurologist should classify this patient's headaches into one of the following groups, and indicate recommendations for further actions.

25. Headache diagnosis: acute symptomatic headache
- ☐ Yes, very likely
- ☐ No, very unlikely
- ☐ Uncertain

25A. If "Yes, very likely," specify: _____

26. Headache diagnosis: chronic benign headache --> if "Yes, very likely," identify the most likely headache syndrome(s) present in this patient (Items 26A-26D).
- ☐ Yes, very likely
- ☐ No, very unlikely
- ☐ Uncertain

26A. Migraine
- ☐ Yes
- ☐ No

26B. Tension type
- ☐ Yes
- ☐ No

26C. Chronic daily
- ☐ Yes
- ☐ No

26D. Other
- ☐ Yes
- ☐ No

26D-1. If Yes, specify: _____

27. Diagnostic Plan (answer each of Items 27A through 27D):

27A. Neuroimaging
- ☐ Yes
- ☐ No

27A-1. Urgency
- ☐ Urgently (within 24 hours)
- ☐ Non-urgently (> 24 hours)

27A-2. Head CT scan
- ☐ Yes
- ☐ No

27A-3. Brain magnetic resonance (MRI)
- ☐ Yes
- ☐ No

27A-4. Brain magnetic resonance angiogram (MRA)
- ☐ Yes
- ☐ No

27A-5. Brain magnetic resonance venography (MRV)
- ☐ Yes
- ☐ No

27A-6. Other
- ☐ Yes
- ☐ No

27B. Lumbar puncture
- ☐ Yes
- ☐ No

27C. Labwork
- ☐ Yes
- ☐ No

27D. Other
- ☐ Yes
- ☐ No

28. Treatment recommendation (answer each of Items 28A through 28D):

28A. PRN rescue or abortive headache medication
- ☐ Yes
- ☐ No

28B. Daily preventive headache medication
- ☐ Yes
- ☐ No

28C. Habit modifications and/or dietary restrictions
- ☐ Yes
- ☐ No

28D. Other
- ☐ Yes
- ☐ No

Staff I.D. #: _____