Lake Pointe Pediatric Associates, P.A.

Headache and Stomach Ache Parent Questionnaire

(Patient Name) (Date of Birth) (Date)

1. How long has your child had the complaint? (weeks, months, etc)

2. Frequency of pain onset: (daily, weekly, etc)

3. Duration: (min, hours, all day, etc)_____ Time of day: (morning, evening, any time)_____

4. Location (site) of pain:

5. Character: (burning, sharp, dull ache, etc.)

6. Influencing factors: (relation to meals, exercise, emotional, etc)

7. Associated Symptoms: nausea, vomiting, fatigue, dizziness, pain elsewhere)

8. Relieved by : (lying down, medication, nothing, etc)

9. Medications tried:

10. Has child experienced constipation recently:

11. **Girls** - Have menstrual periods begun? Yes _____ Age of first period _____ No _____

12. Previous test performed:

13. Patient major personality traits: (nervous, bad tempered, overly conscientious, etc.)

14. Is there any blood relatives of the patient with "nervous stomach", ulcers, or other intestinal problems, migraine or Tension headaches, epilepsy or convulsions? _____

15. Parent, do you have any suspicion as to the cause?

    Are you worried about a particular disease?

    Are there been any new changes in the household structure?

(For additional writing space, please use the back of this page

PATIENT NAME: DOB: TODAY'S DATE:

DATE:	MIGRINE 1	MIGRAINE 2	MIGRAINE 3	MIGRAINE 4	MIGRAINE 5	
TIME BEGAN:						
TIME ENDED:						
INTENSITY 1-10:						
ACTIVITY WHEN MIGRIANE STARTED:						
PRECEDING SYMPTOMS:						
TRIGGERS:						
LOCATION OF PAIN:						
SYMPTOMS DURING MIGRAINE:						
DESCRIPTION OF PAIN:						
MEALS BEFORE MIGRAINE:						
SYMPTOMS AFTER MIGRAINE:						