## Headache Self-Report

Do you have pressure at the base of your head? 1

Yes  No

Does your pain radiate behind your eyes? 2

Yes  No

Does your pain radiate to your neck or shoulders? 2

Yes  No

Is the pain worsened by coughing, crying, laughing, sneezing, orgasms, bowel movements? 1

Yes  No

Do you have general neck pain/stiffness? 2

Yes  No

## Ocular Self-Report

Do you have pain or pressure behind your eyes? 3

Yes  No

Are you sensitive to light? 3

Yes  No

Do you have blurred vision? 3

Yes  No

Do you have double vision? 3

Yes  No

Are you missing a portion of your visual field when looking straight ahead (Field Cuts) with either or both eyes? 3

Yes  No

## Otoneurological Self-Report

Do you have pressure in your ears? 3

Yes  No

Do you have dizziness with position changes? 2

Yes  No

Do you have feelings of unsteadiness when standing? 3

Yes  No

Do you have feelings of unsteadiness when walking? 3

Yes  No

Do you have high-pitched ringing in your ears? 3

Yes  No

Do you have tremors? 3

Yes  No

Do you have decreased hearing? 3

Yes  No

Do you have very sensitive hearing? 3

Yes  No

Do you have vertigo (feelings that you or the room are spinning)? 3

Yes  No

## Cranial Nerve-Brainstem Self-Report

Do you have difficulty swallowing? 2

Yes  No

Do you have throat tightness? 3

Yes  No

Do you have difficulty speaking? 3

Yes  No

Is your voice changing, becoming hoarse? 3

Yes  No

Do you have sleep apnea? 2

Yes  No

Do you snore? 3

Yes  No

Have you ever “passed out”? 2

Yes  No

Do you have palpitations? 3

Yes  No

Do you ever have shortness of breath? 3

Yes  No

Do you have frequent nausea? 3

Yes  No

## Extracranial Self-Report

Do you suffer from prickling, tingling or numbness of your extremities? 2

Yes  No

Do you have increased sensitivity to pain or touch? 2

Yes  No

Do you have diminished sensitivity to pain? 2

Yes  No

Do you have partial or complete loss of sensation in your extremities? 2

Yes  No

Do you have an abnormal burning pain in your extremities? 2

Yes  No

Do you have pain or decreased sensation over a specific portion of your extremities? 2

Yes  No

Do you have any noticeable skin changes? 3

Yes  No

If you close your eyes or are in the dark, do you have difficulty with your balance? 3

Yes  No

Do you have weakness of your extremities? 2

Yes  No

Do you have loss of muscle tone? 2

Yes  No

Do you have difficulty picking up small objects with your fingers? 3

Yes  No

Do you have stiffness of your arms or legs? 3

Yes  No

## Urological Self-Report

Do you have difficulty controlling the urge to urinate? 3

Yes  No

Do you have urinary incontinence (Have you accidentally leaked urine)? 3

Yes  No

Do you have difficulty initiating your urine stream? 3

Yes  No

Do you urinate more than 10 times per day? 3

Yes  No

Do you go two or more times in succession before completely emptying your bladder? 3

Yes  No

Do you awaken from sleep two or more times to urinate? 3

Yes  No

Do you have a history of recurring urinary bladder or kidney infections? 3

Yes  No

Have you ever been diagnosed with interstitial cystitis? 3

Yes  No

Have you ever been diagnosed with a urethral stricture or prostate problems? 3

Yes  No

## Gastrointestinal Self-Report

Do you have constipation? 3

Yes  No

Do you suffer from diarrhea? 3

Yes  No

Have you had occasional incontinence for stools (fecal soiling)? 3

Yes  No

Have you ever been diagnosed with irritable bowel syndrome (IBS)? 3

Yes  No

Have you ever been diagnosed with celiac disease or gluten sensitivity? 3

Yes  No

Have you ever been diagnosed with Crohn's disease or colitis? 3

Yes  No

## Sexual Self-Report

Do you have a decreased interest in sex (reduced libido)? 3

Yes  No

Do you have difficulty maintaining arousal? 3

Yes  No

Do you have difficulty reaching orgasm? 3

Yes  No

Have you lost the ability to reach an orgasm, sustain an erection, or ejaculate properly? 3

Yes  No

Have you experienced a decrease or loss of sensation in your pelvic (or genital) area? 3

Yes  No

## Cognitive Self-Report

Do you suffer from short-term memory loss? 3

Yes  No

Do you suffer from long-term memory loss? 3

Yes  No

Do you have difficulty making decisions? 3

Yes  No

Do you have word finding problems? 3

Yes  No

Do you suffer from depression? 3

Yes  No

Do you suffer from irritability? 3

Yes  No

## Systemic Self-Report

Do you suffer from chronic fatigue? 3

Yes  No

Do you have nipple discharge? 4

Yes  No

Do you have joint hypermobility? 2

Yes  No

Do you have wound healing problems? 3

Yes  No

Have you been diagnosed with thyroid problems? 3

Yes  No

Have you been diagnosed with any pituitary problems? 3

Yes  No

Have you experienced any bleeding or blood clotting disorders? 3

Yes  No

Women: Do you have irregular periods? 3

Yes  No

Women: Do you have unexpected milk production at the breast? 3

Yes  No

## Precipitating Causes

Neurologic testing

MRI Brain 1

Yes  No Date of test/image:

Cine MRI (CSF flow study) 2

Yes  No Date of test/image:

MRI Cervical Spine 2

Yes  No Date of test/image:

MRI Thoracic Spine 2

Yes  No Date of test/image:

MRI Lumbar Spine 2

Yes  No Date of test/image:

CT Head 3

Yes  No Date of test/image:

CT Cervical Spine 3

Yes  No Date of test/image:

CT Thoracic Spine 3

Yes  No Date of test/image

CT Lumbar Spine 3

Yes  No Date of test/image:

CT Myelogram 3

Yes  No Date of test/image:

X-ray Skull 3

Yes  No Date of test/image:

X-ray Shunt Series 3

Yes  No Date of test/image:

X-ray Cervical Spine 3

Yes  No Date of test/image:

X-ray Thoracic Spine 3

Yes  No Date of test/image:

X-ray Lumbar Spine 3

Yes  No Date of test/image:

PET Scan: Brain 3

Yes  No Date of test/image:

Lumbar Puncture 3

Yes  No Date of test/image:

Stellate Ganglion Block 3

Yes  No Date of test/image:

Other: 4

Date of test/image:

Misc. Testing

Vestibular Function Testing 3

Yes  No Date of test/image:

Tilt Table 3

Yes  No Date of test/image:

Holter Monitor 3

Yes  No Date of test/image:

Barium Swallow 3

Yes  No Date of test/image:

Sleep Apnea Monitoring 3

Yes  No Date of test/image:

Sleep EEG Monitoring 3

Yes  No Date of test/image:

Pulmonary Function Tests 3

Yes  No Date of test/image:

Other: 3

Date of test/image:

Laboratory

Pituitary Hormone Profile 3

Yes  No Date of test/image:

Lyme Titer 3

Yes  No Date of test/image:

Rheumatology Panel 3

Yes  No Date of test/image:

Other: 3

Date of test/image:

Consultations

Pain Management 3

Yes  No Date of test/image:

Neurology 1

Yes  No Date of test/image:

Neuropsychology 3

Yes  No Date of test/image:

Cardiology 3

Yes  No Date of test/image:

Rheumatology 3

Yes  No Date of test/image:

Allergist 3

Yes  No Date of test/image:

Nutritional Assessment 3

Yes  No Date of test/image:

Coagulation/Hematology 3

Yes  No Date of test/image:

ENT/Otolaryngology 3

Yes  No Date of test/image:

Orthopedics 3

Yes  No Date of test/image:

Endocrinology 3

Yes  No Date of test/image:

Genetics 2

Yes  No Date of test/image:

Urology 3

Yes  No Date of test/image:

Other: 4

Date of test/image:

## Instructions

*Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.*

### Specific Module Instructions:

Headache Symptoms:

There are Core and Supplemental–Highly Recommended data elements in this module.

Ocular Symptoms:

There are no Core or Supplemental–Highly Recommended data elements in this module. All data elements are Supplemental and could be collected on clinical studies only if research team considers them appropriate for their study.

Otoneurological Symptoms:

There is one Supplemental–Highly Recommended data element in this module. All other data elements are Supplemental and could be collected on clinical studies only if research team considers them appropriate for their study.

Cranial Nerve-Brainstem Symptoms:

There are Supplemental–Highly Recommended data elements in this module.

Extracranial Symptoms:

There are Supplemental–Highly Recommended data elements in this module.

Urological Symptoms:

There are no Core or Supplemental–Highly Recommended data elements. All data elements are Supplemental and could be collected on clinical studies only if research team considers them appropriate for their study.

GI Symptoms:

There are no Core or Supplemental–Highly Recommended data elements in this module. All data elements are Supplemental and could be collected on clinical studies only if research team considers them appropriate for their study.

Sexual Symptoms:

There are no Core or Supplemental–Highly Recommended data elements in this module. All data elements are Supplemental and could be collected on clinical studies only if research team considers them appropriate for their study.

Cognitive Symptoms:

There are no Core or Supplemental–Highly Recommended data elements in this module. All data elements are Supplemental and could be collected on clinical studies only if research team considers them appropriate for their study.

Systemic Symptoms:

There is one Supplemental–Highly Recommended and one Exploratory data element in this module.

Precipitating Causes:

There are Core, Supplemental–Highly Recommended, and Exploratory data elements in this module.