SIH: PATIENT QUESTIONNAIRE

First Name: _____ Last Name: _____

Date of Birth *(mm/dd/yyyy)* _____/_____/_____

What is your biological sex:

☐ Male

☐ Female

1. **Please select your race:**

☐ White/Caucasian

☐ Black/African

☐ Asian American/Pacific Islander

☐ Native American/Indigenous American

☐ Hispanic-Latinx American

☐ Non-Hispanic/Latinx

☐ Other

2. **Please select your ethnicity:**

☐ Hispanic or Latino

☐ NOT Hispanic or Latino

☐ Decline to answer

3. **What is your primary medical insurance?**

☐ Private

☐ Government

☐ Uninsured / Self-pay

4. **What is your current occupation?**

☐ Currently working (includes self-employed status)

☐ Student

☐ On disability

☐ Retired

☐ Unemployed

MEDICAL HISTORY

5. **Which of the following have you had?**

☐ Whiplash ☐ Concussion ☐ Skull fracture ☐ None of the above

Which of the following medical conditions have you been diagnosed with?

☐ Mixed connective tissue disease

☐ Ehler Danlos syndrome

☐ Postural orthostatic tachycardia syndrome (POTS)

☐ Meningitis or brain infection

☐ None of the above

6. **Have you ever been double-jointed or been able to touch your toes while standing straight?**

☐ Yes ☐ No

7. **Have you ever been formally diagnosed with any of the following? If only suspected or under investigation, select those that are "suspected."**

☐ Spontaneous intracranial hypotension (SIH) or spontaneous spinal CSF leak

☐ Migraine

☐ New daily persistent headache (NDPH)

☐ Connective tissue disease (i.e., Ehlers Danlos Syndrome, hypermobility syndrome, Marfan syndrome)

☐ Postural orthostatic tachycardia syndrome (POTS)

☐ Idiopathic intracranial hypertension (IIH / pseudotumor cerebri / High pressure headache)

☐ Cervicogenic headache

☐ Degenerative joint disease (arthritis) of the spine

☐ None of the above

PRIOR PROCEDURES Have you ever had the following:

8. **Lumbar puncture (Spinal tap):**

☐ Yes ☐ No

Please provide the month/year of lumbar puncture, if known: _____

What was the opening pressure, if known? _____

9. **Epidural injection (Spinal anesthesia):**

☐ Yes

☐ No

If yes:

Please provide the month/year of epidural injection, if known: _____

10. **Untargeted (blind) blood patch:**

☐ Yes

☐ No

If yes:

☐ **At bedside**

☐ **Under X-ray/imaging-guidance**

Please provide the month/year of untargeted (blind) blood patch, if known:

_____

Did your symptoms improve after the untargeted (blind) blood patch?

☐ Yes

☐ No

If yes:

Please provide the month/year of the untargeted (blind) blood patch that resulted in an improvement of symptoms, if known: _____

11. **Targeted (CT-Myelogram) blood patch:**

☐ Yes

☐ No

If yes:

Please provide the month/year of the targeted (CT-Myelogram) blood patch, if known:

_____

Did your symptoms improve after the targeted (CT-Myelogram) blood patch:

☐ Yes

☐ No

If yes:

Please provide the month/year of the targeted (blind) blood patch that resulted in an improvement of symptoms: _____

12. ☐ **Check the box if you have never had a lumbar injection, epidural injection, untargeted (blind) blood patch, or a targeted (CT-Myelogram) blood patch**

HEADACHE HISTORY AND CHARACTERISTICS

13. **BEFORE the onset of positional symptoms, did you have either of the following headache disorder(s)?**

☐ Idiopathic Intracranial Hypertension (IIH) / Pseudotumor cerebri

☐ Migraine

At what age did your headache condition (from above) begin? _____

14. Have you regularly experienced any of the following?

Symptom	This symptom is usually associated with the positional headache	This symptom occurred prior to or existed before developing the positional headache	This is my most bothersome symptom (only select one)
Neck pain	☐	☐	☐
Vertigo (Dizziness)	☐	☐	☐
Pain in the back of your head	☐	☐	☐
Pain in the front of your head	☐	☐	☐
Headache developing when standing	☐	☐	☐
Headache when waking up in the morning (when first opening eyes before getting out of bed)	☐	☐	☐
Headache developing later in the day (afternoon/evening)	☐	☐	☐
Complete improvement when lying flat	☐	☐	☐
Incomplete improvement when lying flat	☐	☐	☐
Improvement in a pool (I.e., a swimming pool or bath) or other still body of water	☐	☐	☐
Muffled hearing or fullness in your ears (aural fullness)	☐	☐	☐
Ringing in the ears (tinnitus)	☐	☐	☐

Symptom	This symptom is usually associated with the positional headache	This symptom occurred prior to or existed before developing the positional headache	This is my most bothersome symptom (only select one)
Numbness or tingling in your arms (paresthesias)	☐	☐	☐
Pain or discomfort between shoulder blades (intrascapular pain)	☐	☐	☐
Sensitivity to sound (phonophobia)	☐	☐	☐
Sensitivity to light (photophobia)	☐	☐	☐
Nausea or vomiting	☐	☐	☐
Vision changes	☐	☐	☐
Muscle spasm or twitch	☐	☐	☐
Gait disturbances	☐	☐	☐
Swelling or discoloration of hands or feet (extremity edema, non-lymphedema)	☐	☐	☐
Pelvic pain	☐	☐	☐

15. **If you experienced any of the above symptoms, which symptom started first?**

_____

RECENT HEADACHE HISTORY

16. Have your positional symptoms caused you to quit or reduce hours at work?

☐ Yes

☐ No

17. Which of the following have you tried for your positional headache?

Therapy	Did this improve headache symptoms?	
Bed rest	☐ Yes	☐ No
Hydration	☐ Yes	☐ No
Steroids (prednisone, dexamethasone, Medrol Dose Pak)	☐ Yes	☐ No
Caffeine	☐ Yes	☐ No
Abdominal binder or waist trainer	☐ Yes	☐ No
Compression stocking	☐ Yes	☐ No

18. Do you consume more caffeine (coffee, tea, chocolate, other caffeine equivalent) now than you did before the onset of your positional symptoms?

☐ Yes

☐ No

MIGRAINE HISTORY

19. Do you have any history of migraine?

☐ Yes

☐ No

If yes:

Does anyone in your direct family have migraine (father, mother, grandparents)?

☐ Yes

☐ No

If yes, who? _____

Did you get carsick as a child?

☐ Yes

☐ No

Have you ever fainted or felt like fainting (i.e., with blood draws)?

☐ Yes

☐ No

Did your migraine start before or after your positional symptoms?

☐ Before

☐ After

20. Have you been prescribed any of the following classes of medications to treat your CURRENT symptoms?

Drug class (specific drug names are listed under class name)	**Has this medication been effective?**	
☐**Triptan** • Almotriptan (Axert) • Eletriptan (Relpax) • Frovatriptan (Frova) • Naratriptan (Amerge) • Rizatriptan (Maxalt) • Sumatriptan (Imitrex, Onzetra Xsail, Sumavel DosePro, Zembrace) • Zolmitriptan (Zomig)	☐ Yes	☐ No
☐**Dihydroergotamine (DHE)** • Migranal • Trudhesa • DHE Intramuscular	☐ Yes	☐ No
☐**Lasmiditan (Reyvow)**	☐ Yes	☐ No
☐**CGRP monoclonal antibody** • Aimovig (erenumab) • Ajovy (fremanezumab) • Emgality (galcanezumab) • Vyepti (eptinezumab)	☐ Yes	☐ No
☐**CGRP Gepant** • Nurtec ODT (rimegepant) • Qulipta (atogepant) • Ubrelvy (ubrogepant)	☐ Yes	☐ No
☐**Opioids** • Codeine • Hydrocodone (Vicodin, Norco) • Hydromorphone (Dilaudid) • Methadone • Tramadol • Butorphanol • Morphine • Oxycodone (Percocet, Oxycontin) • Fentanyl	☐ Yes	☐ No
☐**Acetazolamide (Diamox)**	☐ Yes	☐ No