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Supplementary

The study protocol for a multicenter observational headache registry: Brazilian Headache Registry - REBRACEF II

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Supplementary material

1) Baseline questionnaire

1.1) **Patient Selection Criteria** (for the research team)
Interviewer's Identification Number:
Interviewer's Name:
Inclusion Criteria:
( ) Age 18 years or older
( ) Complaint of headache
( ) First appointment
Meets inclusion criteria?
( ) Yes
( ) No
Exclusion Criteria:
( ) Patients with cognitive limitations to understand the informed consent form or structured questionnaire
Meets exclusion criteria?
( ) Yes
( ) No
Does the patient agree to participate in the study?
(Please attach the Informed Consent Form with date and signatures)
( ) Yes
( ) No
Region:
( ) North
( ) Northeast
( ) Midwest
( ) Southeast
( ) South
Center:
( ) Primary care
( ) Secondary care
( ) Tertiary care

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Medical Record Number:
Screening Date:
Referral Source:
( ) Primary care
( ) Secondary care
( ) Tertiary care
( ) Other (specify)

Patient Questionnaire
1.2) Identification Data:
Full Name:
Date of Birth:
CPF (Individual Taxpayer Registration):
Home Phone (include area code):
Cell Phone 1 (include area code):
Cell Phone 2 (include area code):
Email:
Address:
Street Name/Avenue:
Number:
Complement (house/apartment/block):
Neighborhood:
City:
State:
ZIP Code:
Health Insurance:
( ) Unified Health System (SUS)
( ) Private Health Plans
( ) Private

1.3) Sociodemographic Data
Date of birth:
Current date:

What is your gender?
( ) Female
( ) Male
( ) Other
( ) Not informed

What is your ethnicity or race?
( ) Asian
( ) White
( ) Indigenous
( ) Brown/Mixed Race
( ) Black
( ) Not informed

What is your marital status?
( ) Single
( ) Married or in a stable union
( ) Separated or divorced
( ) Widowed
( ) Not informed

What is your level of education?
( ) Illiterate
( ) 1 to 4 years of schooling
( ) 5 to 8 years of schooling
( ) 9 to 11 years of schooling
( ) 12 or more years of schooling
( ) Not informed

Performs paid activity?
( ) Yes
( ) No

What is your profession or occupation?
( ) Self-employed or freelancer
( ) Homemaker
( ) Employed with formal contract
( ) Employed without formal contract
( ) Business owner or employer
( ) Student
( ) Public servant
( ) Retired
( ) Unemployed
( ) Not informed

Do you work in shifts or on call?
( ) Yes
( ) No

Do you have child(ren)?
( ) Yes
( ) No
If yes, how many?
What is your monthly family income?
( ) Less than one minimum wage
( ) Between 1 and 5 minimum wages
( ) Between 5 and 10 minimum wages
( ) Between 10 and 20 minimum wages
( ) More than 20 minimum wages
( ) Not informed

1.4) Anthropometric Data
Weight (in kilograms):
Height (in centimeters):

1.5) Lifestyle Habits
Do you engage in physical exercise?
( ) No
( ) Yes, up to 2 times a week
( ) Yes, 3 or more times a week

If yes, what type of physical exercise do you engage in?
( ) Aerobic (walking, running, cycling, boxing, dancing, etc.)
( ) Non-aerobic (weightlifting, pilates, yoga, etc.)

Do you smoke?
( ) Yes
( ) No
( ) Former smoker in abstinence (quit less than 6 months ago)

( ) Former smoker (quit 6 months ago or more)

Do you consume alcoholic beverages?
( ) Yes, up to 2 times a week
( ) Yes, 3 to 6 times a week
( ) Yes, daily
( ) I do not consume alcoholic beverages habitually

Do you use psychoactive substances?
(for example, marijuana, cocaine, crack)
( ) Yes
( ) No
( ) I stopped using less than 6 months ago
( ) I stopped using 6 months ago or more
If yes, which one(s)?

Do you consume caffeine in quantities equal to or greater than 8 small cups (coffee cup, 60 mL) of black coffee per day?
( ) Yes
( ) No

1.6) Headache
How old were you when the headache started?

Is your headache localized on one side of the head? (select only one option)
( ) Yes, always on the left side
( ) Yes, always on the right side
( ) Yes, sometimes on the left side, sometimes on the right side
( ) No

What is the location of your headache?
( ) Holocranial (entire head)
( ) Frontal
( ) Temporal
( ) Occipital
( ) Parietal
( ) Vertex
( ) Periorbital
( ) Facial

How is the headache that bothers you the most?
( ) Throbbing or pulsating
( ) Tightness or pressure
( ) Stabbing or piercing
( ) Burning

What is the intensity of the headache attacks that bother you the most?
( ) Mild (do not interfere with daily activities)
( ) Moderate (interfere, but do not prevent daily activities)
( ) Severe (prevent daily activities, are disabling)

Mark the intensity of your headache attacks, considering 0 (zero) as "no pain" and 10 (ten) as "the worst pain imaginable":
( ) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10

When you have a headache, what happens if you move?
(for example, walk or climb stairs)
( ) The headache does not change
( ) The headache improves
( ) The headache worsens
( ) When I have a headache, I prefer not to move

What is the usual duration of your headache attacks in the last 3 months? (you can respond in seconds, minutes, hours, or days)

What is the usual frequency of your headache attacks in the last 3 months? (number of attacks per day, week, month, or year)

Do you experience any of these symptoms in a headache attack? (check as many options as you wish)
( ) Nausea
( ) Vomiting(s)
( ) Abdominal pain
( ) Diarrhea
( ) Constipation
( ) Discomfort with light
( ) Discomfort with noises
( ) Discomfort with smells
( ) Dizziness or vertigo
( ) Ringing in the ears (tinnitus)
( ) Fatigue/tiredness
( ) Restlessness
( ) Watery eyes in one eye
( ) Watery eyes in both eyes
( ) Redness in one eye
( ) Redness in both eyes
( ) Nasal obstruction on one side
( ) Nasal obstruction on both sides
( ) Runny nose on one side
( ) Runny nose on both sides
( ) Eyelid swelling on one side
( ) Eyelid swelling on both sides
( ) Drooping eyelid on one side
( ) Drooping eyelid on both sides
( ) Pupil changes on one side
( ) Pupil changes on both sides
( ) Redness on the face on one side
( ) Redness on the face on both sides
( ) Increased sweating on the face on one side
( ) Increased sweating on the face on both sides
( ) Pain when combing or touching the hair and/or scalp
( ) Pain or stiffness in the back of the neck (nape)
( ) Pain or stiffness in the front of the neck

( ) Yawning for no reason
( ) Drowsiness
( ) I don't have any symptoms other than headache

If yes, at what point?
( ) Before the headache
( ) During the headache
( ) After the headache
( ) All the time

Just before or during some of your headache attacks, have you ever seen spots, lights, zigzag lines, or "heat wave"-like flickering?
( ) Yes, it starts slowly (in 5 minutes or more)
( ) Yes, it starts suddenly (in less than 5 minutes)
( ) No

If you answered yes to the previous question, does this symptom occur on only one side of the vision?
( ) Yes
( ) No (this symptom occurs on both sides of the vision)

If you answered yes, how long does this symptom last?

Right before or during some of your headache attacks, have you ever experienced numbness or tingling sensation in any part of your body and/or face?
( ) Yes, it starts gradually (in 5 minutes or more)
( ) Yes, it starts suddenly (in less than 5 minutes)
( ) No

If you answered yes to the previous question, does this symptom occur on only one side of the body and/or face?
( ) Yes
( ) No (this symptom occurs on both sides of the body and/or face)

If you answered yes, how long does this symptom last?

Right before or during some of your headache attacks, have you ever experienced difficulty understanding what was spoken or difficulty speaking?
( ) Yes, it starts gradually (in 5 minutes or more)
( ) Yes, it starts suddenly (in less than 5 minutes)
( ) No

If you answered yes to the previous question, how long does this symptom last?
Right before or during some of your headache attacks, have you ever experienced weakness on one side of the body?
( ) Yes, it starts gradually (in 5 minutes or more)
( ) Yes, it starts suddenly (in less than 5 minutes)
( ) No

If you answered yes to the previous question, how long does this symptom last?

Do you think there is something that triggers your headache attacks to start?
( ) Yes
( ) No

If you answered yes to the previous question, which of the following factor(s) can trigger your headache attacks to start? (check as many options as you wish)
( ) Lack or excess of sleep (sleeping too little or too much)
( ) Prolonged fasting (long periods without eating)
( ) Specific foods (certain types of food)
( ) Alcoholic beverages
( ) Menstrual period
( ) Stress
( ) Relaxation after stress
( ) Weather changes
( ) Chewing, smiling, talking, or swallowing
( ) Physical exercise
( ) Excessive brightness (too much light)
( ) Excessive noise (too much noise)
( ) Strong odors (strong smells, perfumes)
( ) Sexual activity
( ) Change of posture (standing up or lying down)
( ) Sneezing, coughing, or lifting weight
( ) Travel by car or bus

When you have a headache, is there anything that makes the pain improve or disappear? (excluding medications)
( ) Yes
( ) No

If you answered yes to the previous question, choose one or more of the following options:
( ) Rest
( ) Sleep
( ) Vomiting
( ) Cold compresses
( ) Warm or hot compresses
( ) Massages
( ) Home remedies
( ) Others, please specify

Does anyone else in your family have (or had) headaches similar to yours?
( ) Yes, first-degree relative (parent, sibling, child)
( ) Yes, other relatives
( ) No
( ) I don't know

Do you use any medication to treat headache attacks? (acute treatment medications)
( ) Yes
( ) No

If you answered yes to the previous question, which medication(s) do you use?

Does this medication work?
( ) Yes
( ) No
( ) Partially

If you use any medication to treat headache attacks, how often do you usually use this medication? (on average)
( ) Less than 1 day per month
( ) 1 day per month
( ) 2 days per month
( ) 3 days per month
( ) 1 day per week
( ) 2 days per week
( ) 3 days per week
( ) 4 days per week
( ) 5 days per week
( ) 6 days per week
( ) Every day

Do you use any medication to prevent headaches?
( ) Yes
( ) No

If you answered yes to the previous question, which medication(s) do you use?

If you answered yes, does this medication work?
( ) Yes
( ) No
( ) Partially

Have you ever used other medication(s) to prevent headaches?
( ) Yes
( ) No

If you answered yes to the previous question, which medication(s) have you used?

If you answered yes, why did you stop the treatment(s)?
( ) Cost
( ) Undesired effects
( ) No improvement
( ) Other (specify)

Have you undergone or are currently undergoing any other type of evaluation and/or treatment for your headache? (check as many options as you wish)
( ) Acupuncture
( ) General practitioner
( ) Physiatrist
( ) Physiotherapist
( ) Gastroenterologist
( ) Gynecologist
( ) Homeopathy
( ) Massage therapy
( ) Neurologist
( ) Neurosurgeon
( ) Nutritionist
( ) Dentist
( ) Ophthalmologist
( ) Orthopedist
( ) Otorhinolaryngologist
( ) Psychiatrist
( ) Psychologist
( ) Other medical specialties (cardiologist, endocrinologist, gastroenterologist, etc.)
( ) Other, please specify:
( ) I have never undergone any other type of evaluation/ treatment

If you underwent any other type of evaluation and/or treatment for your headache, how was it financed?
( ) Brazil's Unified Health System (SUS)
( ) Health insurance
( ) Private/Out-of-pocket

1.7) Impact

In this module, you will answer questions about how headaches affect your life.
Did you seek emergency care for your headache in the last 12 months?
( ) Yes
( ) No

If you answered yes to the previous question, how many times did you seek emergency care in the last 12 months?
Did you require hospitalization or overnight stay due to your headache in the last 12 months?
( ) Yes
( ) No

If you answered yes to the previous question, how many days were you hospitalized or required overnight stay?

Did you attend outpatient medical appointments due to your headache in the last 12 months?
( ) Yes
( ) No

If you answered yes to the previous question, how many appointments did you attend in the last 12 months?

Have you undergone a CT scan or angiography, MRI or MR angiography of the skull due to your headache?
( ) Yes
( ) No

If yes, which one(s)?
( ) Computed tomography of the skull
( ) Computed tomography angiography of intracranial

vessels
( ) MRI of the skull
( ) Magnetic resonance angiography of intracranial vessels
( ) CT scan of the cervical spine
( ) Computed tomography angiography of cervical vessels
( ) MRI of the cervical spine
( ) Magnetic resonance angiography of cervical vessels

If you answered yes to the previous question, how many scans have you undergone in the last 12 months?

If yes, who prescribed the scan?
( ) General practitioner
( ) Neurologist
( ) Another specialist doctor
( ) Patient's decision
For the research team: attach any available reports and/or request the patient to bring other reports in subsequent interviews.

1.8) Episodic Syndromes
In this module, you will answer questions about some symptoms that may have occurred during your childhood (these symptoms may be related to adult headaches).

From birth to three months of age, did you have "colic" (excessive crying without a defined cause)?
( ) Yes
( ) No
( ) I don't know

During your childhood, did you have episodes where your head tilted and you became pale and unwell, improving within minutes to days?
( ) Yes
( ) No
( ) I don't know

During your childhood, did you have episodes of dizziness where you or objects seemed to spin, and you became pale and frightened, starting suddenly and improving after a few hours?
( ) Yes
( ) No
( ) I don't know

During your childhood, did you have episodes of vomiting and feeling unwell, without having a fever or diarrhea?
( ) Yes
( ) No
( ) I don't know

During your childhood, did you have episodes of strong stomach pain (in the middle of the stomach) and feeling unwell, without a defined cause?
( ) Yes
( ) No
( ) I don't know

During your childhood, did you often feel nauseous and/or vomit during bus or car trips?
( ) Yes, it still happens
( ) Yes, it doesn't happen anymore
( ) No
( ) I don't know

1.9) Comorbidities
In this module, you will answer questions about other health problems you may have, not necessarily related to your headache.

Do you receive treatment for any chronic diseases? (check as many options as apply)
( ) Anxiety
( ) Asthma
( ) Depression
( ) Diabetes mellitus
( ) Dyslipidemia
( ) Cerebrovascular disease (ischemic or hemorrhagic stroke, TIA)
( ) Moderate to severe liver disease
( ) Moderate to severe kidney disease
( ) Chronic lung disease
( ) Rheumatologic diseases
( ) Peripheral vascular disease
( ) Chronic low back pain
( ) Fibromyalgia
( ) Glaucoma
( ) HIV+/AIDS
( ) Systemic arterial hypertension ("high blood pressure")
( ) Hyperthyroidism
( ) Hypothyroidism
( ) Myocardial infarction
( ) Heart failure
( ) Leukemia, lymphoma, or other tumors
( ) Metastases
( ) Nephrolithiasis (kidney stones)
( ) Osteoporosis
( ) Rhinitis/rhinosinusitis
( ) Irritable bowel syndrome
( ) Polycystic ovary syndrome
( ) Peptic ulcer
( ) Bipolar affective disorder
( ) Borderline personality disorder
( ) I do not receive treatment for chronic diseases

Do you take continuous-use medications?
(excluding those for headache treatment)
( ) Yes
( ) No

If yes, which one(s)?

1.10) Women's questionnaire

The following questions are directed only to female patients. The questionnaire is closed for male patients.

At what age did you have your first menstruation?

Does menstruation affect your headache?
( ) Yes, improves
( ) Yes, worsens
( ) No effect

Are you pregnant?
( ) Yes
( ) No

Have you ever been pregnant?
( ) Yes
( ) No

If you answered yes to the previous question, did pregnancy affect your headache?
( ) Yes, improved
( ) Yes, worsened
( ) No effect

Do you use contraception?
( ) Yes
( ) No

If yes, which one(s)?
( ) Combined oral contraceptive pill
( ) Progestin-only pill
( ) Monthly injectable hormonal contraceptive
( ) Quarterly injectable hormonal contraceptive
( ) Subcutaneous progestin implant (Implanon®)
( ) Copper intrauterine device (IUD)
( ) Hormonal intrauterine device (IUD)
( ) Diaphragm
( ) Patch (Evra®)
( ) Vaginal ring
( ) Barrier method (condom)
( ) Tubal ligation
( ) Vasectomy (partner)

If you use hormonal contraception (pill), has the use of this medication affected your headache?
( ) Yes, improved
( ) Yes, worsened
( ) No effect

Are you in menopause?
( ) Yes
( ) No

If you answered yes to the previous question, did menopause affect your headache?
( ) Yes, improved
( ) Yes, worsened
( ) No effect

Do you use hormone replacement therapy?
( ) Yes
( ) No

If you use hormone replacement therapy, what is the name of the medication?

If you answered yes to the previous question, did hormone replacement therapy affect your headache?
( ) Yes, improved
( ) Yes, worsened
( ) No effect

Medical Team Questionnaire
1.11) Diagnostic

Does the patient have a defined diagnosis?
( ) Yes
( ) No

ICD-10:
( ) G43.0 Migraine without aura
( ) G43.1 Migraine with aura
( ) G43.2 Status migrainosus
( ) G43.3 Complicated migraine
( ) G43.8 Other migraine syndromes
( ) G43.9 Migraine, unspecified
( ) G44.0 Cluster headache syndrome
( ) G44.1 Vascular headache
( ) G44.2 Tension-type headache
( ) G44.3 Post-traumatic headache
( ) G44.4 Drug-induced headache
( ) G44.8 Other specified headache syndromes

Diagnosis according to the International Classification of Headache Disorders – third Edition:
Migraine
( ) Migraine without aura
( ) Migraine with aura
( ) Chronic migraine
( ) Probable migraine
Tension-type headache
( ) Infrequent episodic tension-type headache
( ) Frequent episodic tension-type headache
( ) Chronic tension-type headache
( ) Probable tension-type headache
Trigemino-autonomic cephalalgias
( ) Episodic cluster headache
( ) Chronic cluster headache
( ) Paroxysmal hemicrania
( ) Chronic paroxysmal hemicrania
( ) Episodic SUNCT
( ) Chronic SUNCT

( ) Episodic SUNA
( ) Chronic SUNA
( ) Continuous hemicrania
( ) Probable trigemino-autonomic cephalalgia
Primary headache of group 4 of ICHD-3, which one(s)?

Secondary headache, which one(s)?

Painful cranial neuropathy, which one(s)?

Does the patient present any alterations on the cephalic/neurological examination?
( ) Yes
( ) No
( ) Physical examination was not performed

If yes, which one(s)?

Blood pressure:
Heart rate:

1.12) Conduct Adopted

Acute Treatment
( ) Combination analgesics
( ) Common analgesics
( ) Antiemetics
( ) Nonsteroidal anti-inflammatory drugs (NSAIDs)
( ) Antipsychotics (neuroleptics)
( ) Ergot derivatives
( ) Opioids (alone or in combination)
( ) Inhalatory oxygen
( ) Muscle relaxants
( ) Triptans
( ) Triptan + anti-inflammatory
( ) Other(s), which one(s)?
( ) No acute treatment prescribed

Preventive Treatment (short and long term)
( ) Serotonergic antagonists (Cyproheptadine, Pizotifen, Other)
( ) Anticonvulsants (Carbamazepine, Gabapentin, Lamotrigine, Oxcarbazepine, Pregabalin, Topiramate, Sodium valproate/divalproex, Other)
( ) Angiotensin receptor blocker (Candesartan)
( ) Oral corticosteroids
( ) Non-invasive neuromodulation (1. Cefaly®, Transcutaneous electrical nerve stimulation (TENS), Other)
( ) Monoclonal antibodies (Fremanezumab 225 mg monthly, Fremanezumab 675 mg quarterly, Galcanezumab 240 mg loading dose followed by 120 mg monthly, Other)
( ) Dual antidepressants (Venlafaxine, Desvenlafaxine, Duloxetine, Other)
() Selective serotonin reuptake inhibitors (Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline, Vortioxetine, Other)
( ) Tricyclic antidepressants (Amitriptyline, Nortriptyline, Other)
( ) Beta-blockers (Atenolol, Metoprolol (succinate/tartrate), Propranolol)
( ) Calcium channel blockers (Flunarizine, Verapamil, Other)
( ) Anesthetic blockade of peripheral nerves
( ) Nutraceuticals (Coenzyme Q-10, Magnesium, Riboflavin, Other)
( ) Botulinum toxin type A (155 units quarterly, 195 units quarterly, Other)
( ) Other(s)
( ) No preventive treatment prescribed

Guidance
( ) Headache diary
( ) Sleep hygiene
( ) Regular physical exercise
( ) Discontinuation/reduction of excessive analgesic use
( ) Discontinuation/replacement of combined hormonal contraceptive
( ) Other(s), which one(s)?
( ) No additional guidance provided

Were further tests requested?

( ) Yes
( ) No

If you answered yes to the previous question, which additional test(s) were requested?
( ) Computed tomography of the skull
( ) Computed tomography angiography of intracranial vessels
( ) Magnetic resonance imaging of the skull
( ) Magnetic resonance angiography of intracranial vessels
( ) Computed tomography of the cervical spine
( ) Computed tomography angiography of cervical vessels
( ) Magnetic resonance imaging of the cervical spine
( ) Magnetic resonance angiography of cervical vessels
( ) Lumbar puncture with cerebrospinal fluid analysis
( ) Laboratory tests
( ) Other(s), which one(s)?

Was a referral made to another professional?

( ) Yes
( ) No

If you answered yes to the previous question, which one(s)?

Was a follow-up appointment advised?
( ) Yes
( ) No

If yes, how soon?

1.13) Headache Diary

Brazilian Headache Registry - Headache Diary

Patient: _____

Please record all episodes of headache in this diary and bring it to every appointment, so that the frequency and intensity of your headaches can be monitored.

	JAN	FEV	MAR	ABR	MAI	JUN	JUL	AGO	SET	OUT	NOV	DEZ
1												
2												
3												
4												
5												
6												
7												
8												
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30		//										
31		//		//		//			//		//	

Legend:

C - medical appointment
X - mild attack (does not interfere with work or other activities)
XX - moderate attack (interferes, but does not prevent work or other activities)
XXX - severe attack (prevents work or other activities)
O - use of analgesics

2) Follow up questionnaire

2.1) Clinical Evolution of Headache (compared to Headache Diary)

Have you had headaches in the last three months?
( ) Yes
( ) No

If you answered yes to the previous question, how many headache days have you had in the last 3 months?

If you had headaches, what was the intensity of most of your headache attacks?
( ) Mild (do not interfere with daily activities)
( ) Moderate (interfere, but do not prevent daily activities)
( ) Severe (prevent daily activities, are incapacitating)

Mark the intensity of your headache attacks, considering 0 (zero) as "no pain" and 10 (ten) as "the worst imaginable pain"
( ) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10

If you had headaches, did you use any medication to treat the headache attacks?
( ) Yes
( ) No

If you answered yes to the previous question, which medication(s) did you use?

If you used medication to treat the headache attacks, how often did you use these medications? (on average)
( ) Less than 1 day per month
( ) 1 day per month
( ) 2 days per month
( ) 3 days per month
( ) 1 day per week
( ) 2 days per week
( ) 3 days per week
( ) 4 days per week
( ) 5 days per week
( ) 6 days per week
( ) Every day

2.2) Adverse Events

Did you experience any unwanted effects from the prescribed treatment(s) at your last appointment?
( ) Yes
( ) No

If you answered yes to the previous question, what unwanted effect(s) did you notice?

If you experienced adverse effects, which of the prescribed treatment(s) caused the unwanted effect(s)?

Are you continuing with the prescribed treatment(s) from your last appointment?
( ) Yes
( ) No
( ) Partially

If you answered no or partially to the previous question, what is the reason(s)?

Are you satisfied with the prescribed treatment(s)?
( ) Yes
( ) No
( ) Partially

If you answered no or partially to the previous question, what is the reason(s)?

2.3) Impact

In this module, you will answer questions about how headaches interfere with your life.

Did you seek emergency care for your headache in the last 3 months?
( ) Yes
( ) No

If you answered yes to the previous question, how many times did you seek emergency care in the last 3 months?

Were you hospitalized or did you require overnight hospitalization due to your headache in the last 3 months?
( ) Yes
( ) No

If you answered yes to the previous question, for how many days were you hospitalized or required overnight hospitalization?

Did you have outpatient medical appointments for your headache in the last 3 months?
( ) Yes
( ) No

If you answered yes to the previous question, how many appointments did you have in the last 3 months?

Have you ever had a CT scan or CT angiography, MRI or MR angiography of the head due to your headache?
( ) Yes
( ) No

If you answered yes to the previous question, how many exams have you had in the last 3 months?

For the research team: attach available reports and/or ask the patient to bring other reports to subsequent interviews.

For the research team: record changes in ongoing medications.

2.4) Medical Diagnosis Update

Has there been any change in the patient's diagnosis since the last consultation?
( ) Yes
( ) No

If yes, what is/are the current diagnosis(es)? (check as many options as desired)
Migraine
( ) Migraine without aura
( ) Migraine with aura
( ) Chronic migraine
( ) Probable migraine
Tension-type headache
( ) Infrequent episodic tension-type headache
( ) Frequent episodic tension-type headache
( ) Chronic tension-type headache
( ) Probable tension-type headache
Trigeminoautonomic cephalalgias
( ) Episodic cluster headache
( ) Chronic cluster headache
( ) Episodic paroxysmal hemicrania
( ) Chronic paroxysmal hemicrania
( ) Episodic SUNCT
( ) Chronic SUNCT
( ) Episodic SUNA
( ) Chronic SUNA
( ) Continuous hemicrania
( ) Probable trigeminoautonomic headache

Primary headache of group 4 of the ICHD-3, which one(s)?

Secondary headache, which one(s)?

Painful cranial neuropathy, which one(s)?

Was there a change in the patient's treatment?
( ) Yes
( ) No

If yes, which one(s)?
( ) Modification of the medication
( ) Dosage adjustment
( ) Medication combination
( ) Discontinuation of the medication

What was the reason for the modification of the medication(s)?
( ) Ineffectiveness
( ) Adverse event
( ) Patient's choice
( ) Effectiveness
( ) Other

What was the reason for the dosage adjustment of the medication(s)?
( ) Ineffectiveness
( ) Adverse event
( ) Patient's choice
( ) Effectiveness
( ) Other

What was the reason for the combination of the medication(s)?
( ) Ineffectiveness
( ) Adverse event
( ) Patient's choice
( ) Effectiveness
( ) Other

What was the reason for the discontinuation of the medication(s)?
( ) Ineffectiveness
( ) Adverse event
( ) Patient's choice
( ) Effectiveness
( ) Other