Appendix 1: Patient Questionnaire

Questionnaire: Patients with cochlear implants receiving treatment at UCSF.

1. Age	_________ years
2. Gender	☐ Female ☐ Transgender ☐ Male ☐ Decline to state
3. How many days in the past 30 days did you have a headache?	________ days
4. In the past 30 days, please specify how many days your headache was:	☐ Severe: ______________ ☐ Moderate: _____________ ☐ Mild: ____________
5. **Before** your cochlear implant, how many times per month did you experience headaches?	________/month
6. **Before** your cochlear implant, (if you had headaches), how long did they usually last?	________ hours
7. **After** your cochlear implant surgery, how often did you experience headaches?	________/month
8. **After** your cochlear implant surgery, (if you had headaches) how long did they usually last?	________ hours
9. **After** your cochlear implant surgery, have you had ear pain?	☐Yes ☐No
10. After you **FIRST turned on** your cochlear implant, did your headache **frequency** increase?	☐Yes ☐No
11. After you **FIRST turned on** your cochlear implant, did your headache **severity** increase?	☐Yes ☐No
12. Have you ever experienced significant head trauma?	☐Yes ☐No

13. Does your menstrual cycle trigger headaches?	☐Yes ☐No
14. Does hunger trigger headaches?	☐Yes ☐No
15. Does being tired or lack of sleep trigger headaches?	☐Yes ☐No
16. Do you have a family history of headaches?	☐Yes ☐No
17. Have you had any other brain, head or neck surgery besides the Cochlear implant?	☐Yes ☐No
18. On how many days per month do you take medications to relive pain?	________ days

During a headache, how often do you experience the following?

	Never	**Rarely**	**Sometimes**	**Often**
19. Sensitivity to light (lights seam brighter)	☐	☐	☐	☐
20. Sensitivity to sounds (sounds appear louder)	☐	☐	☐	☐
21. Sensitivity to smells (smells appear stronger)	☐	☐	☐	☐
22. Nausea and or vomiting?	☐	☐	☐	☐
23. Changes in vision?	☐	☐	☐	☐
24. Muscle weakness?	☐	☐	☐	☐
25. Thinking or memory problems?	☐	☐	☐	☐
26. Lightheadedness?	☐	☐	☐	☐
27. Spinning sensation?	☐	☐	☐	☐
28. Imbalance?	☐	☐	☐	☐
29. Tearing from the eye?	☐	☐	☐	☐
30. Nasal congestion or runny nose	☐	☐	☐	☐
31. Swelling/puffy around the eye	☐	☐	☐	☐
32. Redness of the eye	☐	☐	☐	☐
33. Eyelid drooping down	☐	☐	☐	☐

Investigator Comments:

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