Name sticker

Pineal Cyst Questionnaire – BEFORE OPERATION

The information that you provide will remain strictly confidential.

Are you currently at work/school? ☐ yes ☐ no

If no, when did you last work? ……

What is your job? ……..

Is it full time or part time job? ☐ yes ☐ no

If you are off work, is this because of the symptoms you came to see me with?
☐ yes ☐ no

Weight

- now …… kg
- 1 year ago …… kg (approximately if not known precisely)
- 5 years ago or before symptoms started …… kg (approximately if not known precisely)

Do you think that there has been a relationship between weight and symptoms (presence of the symptoms or their severity)? ☐ yes ☐ no
If yes, please, describe.

Medications

	Name	Started*	Stopped*
HRT			
Contraceptive pill			
Hormonal supplements			
Vitamins			
Painkillers			

*Approximate date when you started and stopped taking this medication.

Have you had glandular fever (= infectious mononucleosis)

☐ yes ☐ no

Headache

Do you suffer from more than one type of headache (that are different in nature)? Please describe.

☐ yes ☐ no

Do you suffer from migraines?

☐ yes ☐ no

Do you have constant headache, i.e. headache that is there all the time and never really goes away? ☐ yes ☐ no

If yes, when did it start? ……..years ……..months ago

Where in the head is your 'main headache'? (tick whichever apply to you)

- ☐ Behind the eye – Left/Right
- ☐ Behind the eyes
- ☐ Between the eyes
- ☐ On the back of the head
- ☐ It is like a tight belt
- ☐ On top of the head
- ☐ In the centre of the head
- ☐ Other (please describe)

Which word best describes your 'main headache'?

- ☐ Sharp
- ☐ Like a tight belt/band
- ☐ Like a knife
- ☐ Pulsating
- ☐ Burning
- ☐ Other (please describe)

When did the **'main headache'** start?

Please give an approximate date

Please give an event, if there is one, that the headaches relate to

Did you 'main headache' start before my migraine headaches? □ yes □ no □ n/a

Does anything trigger your **'main headache'**?

□ Sound/noise
□ Looking up
□ Light
□ Other (please describe)

What makes your **'main headache'** worse?

□ Lying flat
□ Sitting up
□ Working on a computer
□ Any light
□ Fluorescent light
□ Noise
□ Other (list as many causes as you want)

When is your **'main headache'** worst?

□ In the morning
□ In the evening
□ Any other time
□ There is no specific time of day when the headache tends to be worse than at other times

When is your **'main headache'** least bad?

□ In the morning
□ In the evening
□ Any other time
□ There is no specific time of day when the headache tends to be better than at other times

Vision

Please tick all boxes next to the statements that apply to you

- ☐ Blurred vision
- ☐ Double vision
- ☐ When turning my head I experience 'delay in seeing the object in front of me'
- ☐ Tired eyes all the time

What makes your vision-related symptoms worse?

- ☐ Light
  - ☐ Daylight
  - ☐ Fluorescing light
  - ☐ Computer light
  - ☐ Describe

- ☐ Eye movement
  - ☐ Looking to the left
  - ☐ Looking to the right
  - ☐ Looking up
  - ☐ In any direction (is there any direction that makes things worse)

Time of day. My vision related problems are worse

- ☐ Towards the end of the day
- ☐ In the morning
- ☐ At night

Do you have any problems when looking up? ☐ yes ☐ no

If yes – what happens/what symptoms you may get?

Balance problems - dizziness

Which of these statements best describes your symptoms?

- ☐ I have a sensation of movement - as if I was on a rotating chair/the room is spinning
- ☐ My legs feel week
- ☐ I feel like have no control of my legs
- ☐ I feel light-headed

Time profile

- ☐ It is there all the time
- ☐ It starts suddenly
- ☐ It comes and goes. It lasts for
  - ☐ seconds ☐ minutes ☐ hours ☐ days

It is triggered by movement – describe what sort of movement(s)

- ☐ Getting up
- ☐ Suddenly moving my head sideways
- ☐ Bending my head backwards
- ☐ Stress
- ☐ Loud noise
- ☐ Closing eyes

Is anything that makes your balance worse?

- ☐ Getting up
- ☐ Suddenly moving my head sideways
- ☐ Turning my head backwards
- ☐ Stress
- ☐ Loud noise
- ☐ Closing eyes

Hearing

- ☐ Reduced hearing problems on the
  - ☐ left ☐ right ☐ both sides
- ☐ Hearing noises
- ☐ Hearing voices

Memory

Any memory problems? ☐ yes ☐ no

Please describe

Speaking

Any speech problems? ☐ yes ☐ no

Please describe

Concentration

Any problems ☐ yes ☐ no

Please describe

Sleep problems

- ☐ I sleep too much
- ☐ I sleep too little
- ☐ Other sleep problems. Please describe

Other important symptoms

Please list and describe

Have you been seen by an ENT surgeon? ☐ yes ☐ no

What was their diagnosis/explanation?

What treatment did they recommend?

Have you been seen by an ophthalmologist? ☐ yes ☐ no

What was their diagnosis/explanation?

What treatment did they recommend?

Have you been seen by a neurologist? ☐ yes ☐ no

What was their diagnosis/explanation?

What treatment did they recommend?