

MBChB Year 2 Clinical contact in GP – Headache 14th May 2026

Overview of the headache session in GP clinical contact

The Intended Learning Outcomes for this session are:

Undertake a clinical consultation & gather information relevant to the patient presentation
Describe & perform a clinical examination relevant to the patient presentation including vital signs
Practise formulating a differential diagnosis
Practise presenting the patient and be able to discuss the differential diagnosis and management options

The aims for this session are:

- To discuss the assessment of headache and associated symptoms in Primary Care.
- Practise consulting and examination (preferably headache).
- Link university learning to Primary Care and share your clinical experience.

Common to all sessions:

- Refer to the [Year 2 GP handbook](#), which covers the information common to all sessions.
- Please see [Session plans for Clinical contact in GP year 2 \(2025-26\)](#) also attached to this email to help you structure time with your group.

Allow time for:

- introductions (reflecting on any learning/action points from the previous session)
- student-led interaction with patient(s), and
- debriefing the group (usually without the patient present) to ask questions and consolidate learning
- **Additionally for this session:** Please allow time for individual feedback. While you speak with individual students the other students should be completing their feedback form (see email information)

Follow the usual timetable of talking to and examining one or two patients:

- Students are introduced to cranial nerve examination in a campus-based tutorial session (see PDFs on **Cranial nerve protocol** so that you know what the students have covered). You may not have time for a full cranial nerve examination; if not, you could demonstrate what aspects you would particularly do in a patient with new or concerning headaches – please **at least** get the students try fundoscopy (how to hold and use a fundoscope; identify the fundus and optic disc)

(Expert) patients

Suitable patients for the block are:

- Patients with chronic or recurrent headaches
- Patients with a previous episode of acute headaches e.g. migraine, tension headaches
- Any patient suitable for headache symptoms examination

Context for the session

Students will have covered the following in the two-week headache block:

In **Case-Based Learning**: a 90-year-old woman who presents to the Emergency Department with a skin tear of her left forearm, instability, right-sided headaches, and a left homonymous hemianopia (brain tumour).

In **lectures, workshops and practicals** students will cover:

- Cerebral circulation, intracranial pressure
- Bleeding and imaging
- Intracranial and extracranial infections leading to headache
- Primary and secondary tumours of the brain
- Lumbar puncture
- Differential diagnosis of headache
- Pathophysiological and pharmacological principles of headache management
- Headache as a presentation of domestic violence
- Cranial nerve examination (students undertake a practical session on this the week prior to coming to you – [see cranial nerve clinical skills protocol](#) for details)
- Applied Anatomy and Imaging Practical (headache)

In their **Effective Consulting labs** students will explore:

- Features of serious headaches (red flags)
- Bystander skills to support colleagues
- How to perform a cranial nerve examination

Brainstorm for headache symptoms in GP clinical contact – see mind map on next page

- What do students know about headache and its causes?
- How do patients with headache pathology present?
- Are there any links between their previous cases e.g. anaemia, bleeding and clotting, chest pain or breathlessness that link to headache pathology?
- How do you assess a patient with headache?
- What are serious features that you look out for in a patient presenting with headache?



Student information

Ways of classifying headaches¹:

- Primary headaches — not associated with an underlying condition, includes tension-type headache, migraine, and trigeminal autonomic cephalgias (including cluster headache). Most headaches are primary
- Secondary headaches — precipitated by another condition or disorder (local or systemic)


Headache causes and features:

- **Tension-type headache** – Often referred to by patients as a “normal” or “ordinary” headache. Consequently, they mostly treat themselves without reference to physicians using over the counter (OTC) medications, generally effectively. Nevertheless, it can be a disabling headache.
Features include bilateral, band-like pressure / tightening, not aggravated by routine activities and tends not to have associated features.
- **Migraine**² – Occurs in 15% of the UK adult population, in women more than men in a ratio of 3:1. An estimated 190,000 attacks are experienced every day, with three quarters of those affected reporting disability. Whilst migraine occurs in children (in whom the diagnosis is often missed) and in the elderly, it is most troublesome during the productive years (late teens to 50's). As a result, over 100,000 people are absent from work or school because of migraine every working day. The cost to the economy may exceed £1.5 billion per annum. Migraine tends to be bilateral or unilateral, pulsating / throbbing, moderate-severe, can be caused by or aggravated by routine activities including stress, menstruation, certain foods and sleep disruption. Associated with sensitivity to light or sound and or nausea or vomiting. Can occur with or without aura. Typical aura symptoms include visual symptoms such as flickering lights, spots or lines and/or partial loss of vision; sensory symptoms such as numbness and/or pins and needles; and/or speech disturbance. Typically lasts 4 to 72 hours.
- **Cluster headache** – Unilateral (around the eye, above the eye and along the side of the head/face), pain can be sharp, boring, burning, throbbing or tightening. Tends to be severe or very severe. Associated with red and or watery eye on the same side as the headache, nasal congestion and/or runny nose, swollen eyelid, forehead and facial sweating, constricted pupil and / or drooping eyelid.
- **Sinusitis** – Headache associated with facial pain/pressure, often worse when bending forward. Usually accompanied by nasal congestion, purulent discharge, and reduced smell. Pain is typically localised to the forehead, cheeks, or behind the eyes depending on the sinus involved.
- **Medication overuse headache**³ – There are no diagnostic tests for primary or medication-overuse headache. This means that the history is vital in making the diagnosis, and time to elicit an accurate history +/- the keeping of a diary for the pattern of attacks can help make a diagnosis.
- **Temporomandibular Joint (TMJ) Dysfunction** – Presents with facial or temporal pain, often worsened by chewing or jaw movement. May be associated with jaw clicking, locking, or bruxism (teeth grinding). Headache is usually localised around the temples.

- **Giant Cell Arteritis (Temporal Arteritis)** – An important cause in patients >50 years old. Presents with new-onset temporal headache, scalp tenderness, and jaw claudication. May have visual symptoms (risk of blindness). Often associated with systemic symptoms (fever, weight loss). Requires urgent treatment.
- **Meningitis** – Presents with headache, fever, neck stiffness, and photophobia. May also include altered consciousness or rash (in meningococcal disease). Rapid onset and systemic illness help distinguish from primary headaches.
- **Subarachnoid Haemorrhage (SAH)** – A medical emergency. Presents with a sudden, severe “thunderclap” headache, often described as the “worst headache of my life.” May include neck stiffness, vomiting, photophobia, or loss of consciousness. Always requires urgent assessment.

Other causes of headache include acute glaucoma, severe hypertension, post-concussion headache, and idiopathic intracranial hypertension

Summary of the headache history

	<p>Introduction</p> <p>“Headache affects nearly everyone at least occasionally. It is a problem at some time in the lives of an estimated 40% of people in the UK. It is one of the most frequent causes of consultation in both general practice and neurological clinics. In its various forms, headache represents an immense socioeconomic burden.” (British Association for the Study of Headache)</p>
<p>You can use SOCRATES to assess headache</p>	
<p>SITE: Global or a specific area? Pain & tenderness in the temples in someone over 50 can indicate temporal arteritis, a band like pain round the head indicates tension headache, one-sided headache may be migraine, an occipital headache may be a subarachnoid haemorrhage.</p> <p>ONSET: When and how (sudden/gradual) did the headache start? Beware the sudden headache at the back of the head, it could indicate a subarachnoid bleed. These tend to be severe, and the patient may describe feeling like they've been hit across the back of the head.</p> <p>CHARACTER: Nature and quality of pain; state of health between attacks - completely well, or residual or persisting symptoms. A migraine may be severe or have neurological features, but patients are symptom-free between episodes.</p> <p>RADIATION: Radiating to the neck could indicate meningitis, the face could indicate trigeminal neuralgia, the scalp could be a feature of giant cell arteritis</p> <p>ASSOCIATED SYMPTOMS: A fever or systemic illness may indicate a viral headache or meningitis; in migraine, patients may experience aura or transient neurological features. Vomiting or visual changes could indicate a space-occupying lesion</p> <p>TIMING: How frequent, and what pattern and duration (especially helpful to distinguish between episodic and daily or unremitting)?</p>	

EXACERBATING/RELIEVING FACTORS: Predisposing and/or trigger factors; aggravating and/or relieving factors; what medication has been tried, what are they currently using?

SEVERITY: Intensity of pain on a scale of 1-10

Headache is a very common presentation. Symptoms suggestive of a serious diagnosis (**red flags**) include:

- Onset after age of 50. Migraine does not usually start after this age
- Worst headache patient has ever had/very rapid onset (subarachnoid haemorrhage)
- History of cancer, especially lung or breast (cerebral metastasis)
- Headache that progressively gets worse over days (tumour or cerebral abscess)
- Headache that wakes patient at night (tumour)
- Early morning vomiting (raised intracranial pressure)
- Unilateral loss of power (TIA/stroke)
- Seizure (tumour)
- Weight loss (tumour or cerebral TB)
- Altered consciousness (meningitis)
- Fever (meningitis)
- Immunodeficiency

What is normal and what has changed?

Consider using a headache diary to aid the diagnosis of primary headaches and to monitor effectiveness of treatment (NICE CG150). Ask the person to record the following for a minimum of 8 weeks:

- frequency, duration, and severity of headaches
- any associated symptoms
- all prescribed and over the counter medications taken to relieve headaches
- possible precipitants
- relationship of headaches to menstruation

SYSTEMS REVIEW – A brief overview (not exhaustive). What you ask depends on the presenting problem and situation and what you have already covered

Systemic: Fever, weight loss, pain.

Cardiovascular & Respiratory: Chest pain, breathlessness (including PND & orthopnoea) palpitations, ankle swelling, cough, wheeze, exercise tolerance normally and any recent change.

Gastrointestinal: Appetite, weight, abdominal pain, swallowing, nausea, changes in bowel habit, jaundice, stool appearance/blood.

Genitourinary: Urinary symptoms (hesitancy, terminal dribbling, dysuria, haematuria, nocturia, incontinence, discharge), menstrual history, pregnancy.

Neurological: Memory, vision, hearing, headaches, fits, faints, funny turns, mood changes, unsteadiness, weakness.

Musculoskeletal: Injuries, joint pain/swelling, muscle pain.

Dermatological: Rash, skin lesions, ulcers

Area e.g. past medical and surgical history

History of migraines, hypertension, immunosuppression, head trauma, obesity

Medication history

Particularly relevant if considering medication-overuse headache, also to establish what the patient has already tried

Family history

Migraine has a strong genetic component

Social, lifestyle and wellbeing – please see specific social and lifestyle history & the “Lifie”

Social, lifestyle, and wellbeing factors don't usually cause headache on their own, but they trigger attacks, increase frequency, or worsen disability. Stress is one of the commonest reported triggers, but headache itself also causes stress. Occupation – check screen use and prolonged concentration & poor ergonomics if neck/shoulder tension. Check sleep. Re diet and hydration check alcohol and caffeine intake, dehydration and migraines may have individual food triggers such as cheese or chocolate. Consider wider social determinants of health. Is there a risk of carbon monoxide poisoning?

- How regular is your sleep and eating?”
- “What’s going on in your life when headaches are worse?”
- “How is headache affecting work, relationships, or caring roles?”
- “What do you do to cope when a headache comes?”

PATIENT PERSPECTIVE (IDEAS, CONCERNS, EXPECTATIONS, IMPACT & EMOTIONS)

It's important to ensure you fully appreciate the ideas the patient has about what's going on, the underlying fears and worries they may have, whether they want reassurance, diagnosis, medication, or referral, what impact the headache is having on their life, and how it is making them feel (ICEIE).

Ideas. What do they think is going on? Possible causes? What have they tried already? Sources of info e.g. What does your partner/ family think?

Concerns. What are they worried is going on or will happen⁴?

Expectations. What are they hoping for?

Impact. How is the problem affecting them?

Emotions. What are the predominant emotions around the problem? Psychological impact.

Useful resources

1. The British Association for the Study of Headaches (BASH) has excellent guidelines on assessment of headache see [0.1 Resources - BASH - The British Association for the Study of Headache](#) (accessed April 2026). We would particularly advise looking at the classification of headache (**section 1.1.4**) and **Table 1** to help you distinguish between common causes of primary headache.
2. Migraine trust charity website is useful: [Home - The Migraine Trust](#)
3. For the EC lab look at [Medication overuse headache - The Migraine Trust](#)
4. Patients presenting with headache may worry about brain tumours. This website talks through the signs and symptoms: [Better safe than tumour - Signs and Symptoms](#)