Pre Treatment
Migraine Headache Questionnaire

Name _____ Date _____

Phone (Home) _____ Phone (Work) _____

Date of Birth _____ Occupation _____

1. How many migraine headaches do you experience per month? _____ on average.
2. How many regular headaches do you have per month? _____ on average.
3. How long do your migraine headaches usually last after you take your migraine medicine?

☐ No more than 2 hours ☐ 3-4 hours ☐ 5-12 hours ☐ 12-24 hours ☐ Several days ☐ 1 week or longer

How long do your migraine headaches usually last if you do not take your migraine medicine?

☐ No more than 2 hours ☐ 3-4 hours ☐ 5-12 hours ☐ 12-24 hours ☐ Several days ☐ 1 week or longer

4. How painful are your migraine headaches? (Circle one number)

1	2	3	4	5	6	7	8	9	10
Mild									Severe

5. Where do your migraine headaches **usually** start from or where are they located? (Check all that apply

Location	Location	Location
☐ Behind right eye	☐ Behind left eye	☐ Behind both eyes
☐ Right temple	☐ Left temple	☐ Both temples
☐ Above right eyebrow	☐ Above left eyebrow	☐ Above both eyebrows
☐ Back of head on right	☐ Back of head on left	☐ Back of head on both sides

7. How old were you when your migraine headaches started? _____
8. How would you describe your migraine headaches ? (Check all that apply)

☐ Throbbing / pounding ☐ Ache / pressure ☐ Like a tight band ☐ Dull ☐ Other

9. Do your migraine headaches awaken you at night?

☐ Never ☐ Occasionally ☐ Often

10. Do any of the following occur before or during your migraine headaches? (Check all that apply)

☐ Nausea	☐ Vomiting	☐ Diarrhea
☐ Bothered by light/noise	☐ Blurred/double vision	☐ Sparkling / flashing / colored lights
☐ Eyelid puffy	☐ Eyelid droops	☐ Loss of vision
☐ Feeling lightheaded	☐ Numbness / tingling	☐ Weakness of arm or leg
☐ Runny nose	☐ Speech difficulty	☐ Loss of consciousness

☐ Other _____

11. Do any of the following bring on your migraine headaches or make them worse? (Check all that apply)

- ☐ Stress (worry, anger)
- ☐ 'Letdown' after stress
- ☐ Air travel
- ☐ Missed meals
- ☐ Certain foods (chocolate, cheese, beer, MSG
- ☐ Bright sunshine
- ☐ Loud noise
- ☐ Fatigue
- ☐ Sexual activity
- ☐ Weather change
- ☐ Heavy lifting
- ☐ Certain smells / perfume
- ☐ Coughing / straining / bending over
- ☐ Other _____

12. Do any of the following make your migraines better? (Check all that apply)

- ☐ Rest
- ☐ Hot compress
- ☐ Cold compress
- ☐ Exercise
- ☐ Massage
- ☐ Quiet and darkness
- ☐ Warm shower
- ☐ Pressure of migraine headache area

13. If you are female, do your migraine headaches change with the following? (Check all that apply)

☐ Menstrual periods ☐ Birth control pills ☐ Pregnancy Other hormonal drugs

14. Do any of your family members have migraine headaches? ☐ No ☐ Yes
If "yes", explain (who) _____

15. Have you ever had a head or neck injury requiring medical treatment? ☐ No ☐ Yes
If "yes", explain _____

16. Have you ever been diagnosed with a health disorder (high blood pressure, asthma, heart disease, ulcer?
☐ No ☐ Yes
If "yes", explain _____ _____

17. Have you ever had your migraine headaches evaluated by a neurologist? ☐ No ☐ Yes
If "yes", when, where, and by whom? _____

_____

What was the diagnosis (Check all that apply)

☐ Migraine ☐ Tension type ☐ Cluster ☐ Other (specify) _____

18. List all past tests you had for your migraine headaches: _____

_____

19. List all past treatment(s) for your migraine headaches: _____

_____

20. Are you taking any *prescription* drugs to treat your migraines? ☐ No ☐ Yes
If "yes", list the medications? _____

_____

How many times in the last month have you used your *prescribed* medications? _____

21. Are you taking any *over-the-counter* drugs to treat your migraines? ☐ No ☐ Yes
If "yes", list the medications? _____

_____

How many times in the last month have you used your *over-the-counter* medications? _____

22. What is your estimated cost per month of your migraine headache medications and visits to the physician? _____

23. How much of these medical expenses are covered by your health insurance? _____

24. How would you rate your general health in the last month? (Check one)
☐ Excellent ☐ Good ☐ Fair ☐ Poor

25. To what extent do your migraine headaches affect your quality of life? (Check one)
☐ Extremely ☐ Moderately ☐ Very little ☐ Not at all