

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.

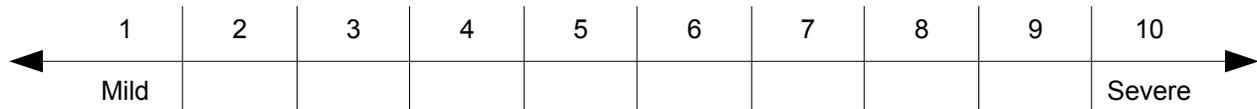
3. How long do your migraine headaches usually last after you take your migraine medicine?

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)



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

Location

Behind right eye

Right temple

Above right eyebrow

Back of head on right

Location

Behind left eye

Left temple

Above left eyebrow

Back of head on left

Location

Behind both eyes

Both temples

Above both eyebrows

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

Bothered by light/noise

Eyelid puffy

Feeling lightheaded

Runny nose

Other _____

Vomiting

Blurred/double vision

Eyelid droops

Numbness / tingling

Speech difficulty

Diarrhea

Sparkling / flashing / colored lights

Loss of vision

Weakness of arm or leg

Loss of consciousness

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

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

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Exercise | <input type="checkbox"/> Quiet and darkness |
| <input type="checkbox"/> Hot compress | <input type="checkbox"/> Massage | <input type="checkbox"/> Warm shower |
| <input type="checkbox"/> Cold compress | <input type="checkbox"/> Pressure of migraine headache area | |

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

- | | | | |
|--|--|------------------------------------|----------------------|
| <input type="checkbox"/> Menstrual periods | <input type="checkbox"/> Birth control pills | <input type="checkbox"/> 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