

Pre Treatment Migraine Headache Questionnaire

Name _____ Date _____

(H) Tel _____ (W) Tel _____

Date of Birth _____ Female Male

Marital Status: Married Single Divorced Widowed

Race: Caucasian Afr. Amer Hispanic Other _____

Education Level: HS grad 2yr degree 4yr degree advanced degree

Occupation _____ Health Insurance Co. _____

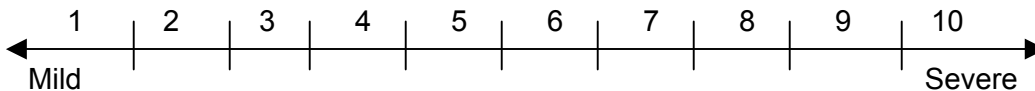
1. How many migraine headaches do you experience per month? _____ on average.

2. How many regular headaches do you have per month? _____ on average.

3. How long do your migraine headaches usually last? (Check one)

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 are your migraine headaches usually located? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Behind right eye | <input type="checkbox"/> behind left eye | <input type="checkbox"/> behind both eyes |
| <input type="checkbox"/> Right temple | <input type="checkbox"/> left temple | <input type="checkbox"/> both temples |
| <input type="checkbox"/> Above right eyebrow | <input type="checkbox"/> above left eyebrow | <input type="checkbox"/> above both eyebrows |
| <input type="checkbox"/> Back of head on right | <input type="checkbox"/> back of head on left | <input type="checkbox"/> back of head on both sides |

6. How old were you when your migraine headaches started? _____

7. How would you describe your migraine headaches? (Check all that apply)

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

8. Do your migraine headaches awaken you at night?

- Never Occasionally Often

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bothered by light/noise | <input type="checkbox"/> Blurred/double vision | <input type="checkbox"/> Sparkling, flashing, or colored lights |
| <input type="checkbox"/> Eyelid puffy | <input type="checkbox"/> Eyelid droops | <input type="checkbox"/> Loss of vision |
| <input type="checkbox"/> Feeling lightheaded | <input type="checkbox"/> Numbness / tingling | <input type="checkbox"/> Weakness of arm or leg |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Speech difficulty | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Other _____ | |

10. 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 or 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 _____ | |

11. Do any of the following make your migraine headaches better?

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Exercise | <input type="checkbox"/> Quiet and darkness |
| <input type="checkbox"/> Hot or cold compress | <input type="checkbox"/> Massage | <input type="checkbox"/> Warm shower |
| <input type="checkbox"/> Pressure over migraine headache area | | <input type="checkbox"/> Other _____ |

12. 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

13. Do any of your family members have migraine headaches?

- No Yes If "yes", explain (who): _____

14. Have you ever had a head or a neck injury requiring medical treatment?

- No Yes If "yes", describe: _____

15. Have you ever been diagnosed to have any health disorder (e.g. high blood pressure, asthma, heart disease, gastric ulcers)?

- No Yes If "yes," please list: _____

16. Have you 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 _____

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

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

19. Are you taking any *prescription* drugs to treat your migraine headaches?

- No Yes If "yes", list the medications: _____
How many times in the last month have you used the *prescribed* medications? _____

20. Are you taking any *over-the-counter* drugs to treat your migraine headaches?

- Yes If "yes", list the medications: _____
How many times in the last month have you used the *over-the-counter* medications? _____

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

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

23. How would you rate your general health in the last month? (Check one)

- Excellent Good Fair Poor

24. To what extent do your migraine headaches affect your quality of life? (Check one)

- Extremely Moderately Very little Not at all