Post Injection
Migraine Headache Questionnaire

Name____Date____________________________________

Part I.

1. Following the injection, how many migraine headaches did you have in the last month? ________________

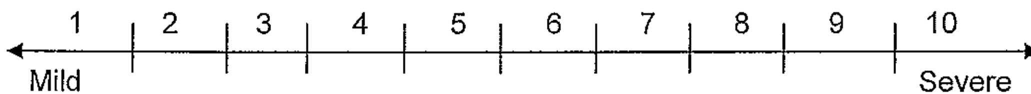
2. How many regular headaches have you had in the last month?___________________________________

If your answer to question (1) above is "0" or "none" do not proceed to Part II of questionnaire.

Part II.

1. How long did the migraine headache(s) last, on average?
   ☐ no more than 2 hours ☐ 3-4 hours ☐5-12 hours ☐12-24 hours ☐several days ☐1 week or longer

2. How painful were your migraine headaches, on average? (circle one number)



3. Was there a change in the character or location of the migraine headache? ☐No ☐Yes
   If "yes," explain:____

4. If you are female, was your migraine during the time of your menstrual cycle? ☐No ☐Yes

5. Did your migraine headache interfere with your normal activities? ☐No ☐Yes

6. Did you lose time from work due to your migraine headache? ☐No ☐Yes
   If "yes," how many days? ____

7. Where was your migraine headache located? (check all that apply)

☐ 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

8. 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, or colored lights
☐Eyelid puffy	☐Eyelid droops	☐Loss of vision
☐Feeling lightheaded	☐Numbness / tingling	☐Weakness of arm or leg
☐Difficulty concentrating	☐Speech difficulty	☐Loss of consciousness
☐Runny nose	☐Other______________________________	

9. 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 or perfume
- ☐ Coughing, straining, bending over
- ☐ Other ______________________________

10. Did you take any *prescription* medications to treat your migraine headache? ☐ No ☐ Yes

If "yes," list the medications: ______________________________

How many times in the last month have you taken the prescribed medications?______________

11. Did you take any *over-the-counter* medications to treat your migraine headache? ☐ No ☐ Yes

If "yes," list the medications:______________________________

How many times in the last month have you taken over-the-counter medications?______________

12. Did you need any treatment, other than medication, to relieve your migraine? ☐ No ☐ Yes

If "yes," please describe: ______________________________

13. How would you rate your general health in the last month?
☐ excellent ☐ good ☐ fair ☐ poor

14. To what extent did this migraine affects the quality of your life?
☐ not at all ☐ very little ☐ moderately ☐ fairly significantly ☐ extremely