

Pre Treatment Migraine Headache Questionnaire

Name _____ Date _____

(H) Tel _____ (W) Tel _____

Date of Birth _____ Female Male

Marital Status: Married Single Divorced Widowed

Race: Caucasion Afr.Amer Hispanic Other _____

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.

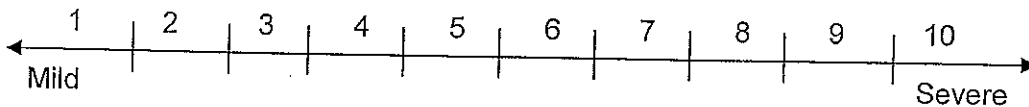
3. How long do your migraine headaches usually last after you take your migraine medicine?

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 located? (Check all that apply)

Location

Location

Location

Behind right eye
Right temple
Above right eyebrow
Back of head on right

behind left eye
left temple
Above left eyebrow
Back of head on left

behind both eyes
both temples
Above both eyebrows
back of head 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

Difficulty concentrating

Runny nose

Vomiting

Blurred/double vision

Eyelid droops

Numbness / tingling

Speech difficulty

Other _____

Diarrhea

Sparkling, flashing, or 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 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 _____ |

12. 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 compress | <input type="checkbox"/> Massage | <input type="checkbox"/> Warm shower |
| <input type="checkbox"/> Cold compress | | <input type="checkbox"/> Pressure over 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 | <input type="checkbox"/> 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 a neck injury requiring medical treatment?

- No Yes If "yes", describe: _____

16. 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: _____

17. 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 _____

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 migraine headaches?

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

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

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