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)

1 2 3 4 5 6 7 8 9 10

Mild Severe

5. Where do your migraine headaches **usually** start from or 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 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, 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_____	

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

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

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

☐Rest ☐Exercise ☐Quiet and darkness
☐Hot compress ☐Massage ☐Warm shower
☐Cold compress ☐Pressure over 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 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?

☐ ☐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