Pre Treatment
Migraine Headache Questionnaire

Name __________________________________________ Date __________________________

Telephone (H): __________________________ Telephone (secondary________________________

Date of Birth:____________ □ Female □ Male

Marital Status: □ Married □ Single □ Divorced □ Widowed

Race: □ Caucasian □ 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? (Check one)
   □ 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? (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)

   1 2 3 4 5 6 7 8 9 10

Mild                       Severe

5. Where are your migraine headaches usually 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

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)
   - 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 __________________________

10. Do 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 ______________________

11. Do any of the following make your migraine headaches better?
    - Rest
    - Exercise
    - Quiet and darkness
    - Hot or cold compress
    - Massage
    - Warm shower
    - Pressure over migraine headache area
    - 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. Have your migraines been treated with Botox?

□ No □ Yes If "yes", when, where, and by whom? ____________________________________________

18. Did the Botox treatment work? □ No □ Yes If "yes", for how long: __________________________

19. What site was the Botox injected? ______________________________________________________

20. List all past tests you had for your migraine headaches: ____________________________________________

21. List all past treatment(s) for your migraine headaches: ____________________________________________

22. 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? ________

23. 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? ________

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

25. How much of these medical expenses are covered by your health insurance? ________________

26. How would you rate your general health in the last month? (Check one)
□ Excellent □ Good □ Fair □ Poor

27. To what extent do your migraine headaches affect your quality of life? (Check one)
□ Extremely □ Moderately □ Very little □ Not at all