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