

## Pre-Treatment Migraine Headache Questionnaire

**Instructions: Please be as specific as possible, and remember to fill out all pages!!**

Name \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Female  Male

Marital Status:  Married  Single  Divorced  Widowed

Ethnicity:  Caucasian  Afr. Amer.  Hispanic  Other \_\_\_\_\_

Education:  HS Grad  2yr degree  4yr degree  Advanced degree

Occupation \_\_\_\_\_ Health Insurance Co. \_\_\_\_\_

1. How many **migraine** headaches do you experience per month? \_\_\_\_\_ on average.

2. How many **regular** headaches do you experience per month? \_\_\_\_\_ on average.

3. How long do your migraine headaches usually last **with medications**?

No more than 2 hours  3-4 hours  5-9 hours  9-12 hours  13-18 hours

19-23 hours  1-2 days  3-4 days  5-6 days  Longer than 1 week

If you checked more than one box, please explain: \_\_\_\_\_

If you had an exceptionally long migraine headache, please describe why:

Menstrual Cycle  Bad Weather  Heat  Increased Stress

Other (please describe): \_\_\_\_\_

4. How long do your migraine headaches usually last **without medications**?

No more than 2 hours  3-4 hours  5-9 hours  9-12 hours  13-18 hours

19-23 hours  1-2 days  3-4 days  5-6 days  Longer than 1 week

If you checked more than one box, please explain: \_\_\_\_\_

If you had an exceptionally long migraine headache, please describe why:

Menstrual Cycle  Bad Weather  Heat  Increased Stress

Other (please describe): \_\_\_\_\_

5. How painful are your migraine headaches? (Circle one number)

1	2	3	4	5	6	7	8	9	10
Mild									Severe

6. 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

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. Do you have any of the following? (Check all that apply)

- Morning migraine       Seasonal allergies       Nasal obstruction

12. 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, or bending over  
 Certain foods (chocolate, cheese, beer, MSG)       Other \_\_\_\_\_

13. 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 \_\_\_\_\_

14. 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       N/A

15. Do any of your family members have migraine headaches?

- No       Yes      If "yes", explain (who): \_\_\_\_\_

16. Have you ever had a head or neck injury requiring medical treatment?

- No       Yes      If "yes", describe: \_\_\_\_\_

17. 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: \_\_\_\_\_

18. 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 \_\_\_\_\_

19. List all past tests you had for your migraine headaches: \_\_\_\_\_

20. List all past treatment(s) for your migraine headaches: \_\_\_\_\_

21. 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? (Please give frequencies separately for each medication) \_\_\_\_\_

22. 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? (Please give frequencies separately for each medication) \_\_\_\_\_

23. What is the estimated cost per month incurred by your migraine headache?

(Include time off from work, cost of medications, clinic visit co-pays, etc.)

24. Approximately what percentage of these medical expenses are covered by your health insurance?

25. How would you rate your general health in the last month? (Mark one)

1	2	3	4	5	6	7	8	9	10
Poor									Excellent

26. Do you experience aura (eyesight changes, hearing changes, numbness/tingling, weakness, difficulty speaking) with your migraine headaches?

Everytime  Never  Occasionally

27. On a scale of 1-10 (1=Not at all, 10=Extremely), how much have migraine headaches affected your quality of life?

1	2	3	4	5	6	7	8	9	10
Mild									Severe

28. Have you had one or more episodes of the following: Chicken Pox, Herpes, Shingles?

No  Yes

If so, have you noticed any association between it and your migraine headaches?

No  Yes

Please explain: \_\_\_\_\_