Pre Treatment
Migraine Headache Questionnaire

Name_______________________________________________    Date ___________________________________

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

4. 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

5. How painful are your migraine headaches? (Circle one number)
   [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10
   Mild [ ] Severe

6. Where is your migraine headaches usually located? (Circle all that apply and indicate which area hurts the most.)
   [ ] Above/Behind the Eye   Right   Left   Both   [ ] Other areas: ________________________________
   [ ] Temporal Area   Right   Left   Both   [ ] Other areas: ________________________________
   [ ] Occipital/Back of Head   Right   Left   Both   [ ] Other areas: ________________________________
   Area that hurts the most: ________________________________

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 puffies   [ ] 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 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 or cold compress   [ ] Massage   [ ] Warm shower
    [ ] Pressure over migraine headache area   [ ] Other ________________________________

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: ________________________________
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?
   □ Migraine □ Tension-type □ Cluster □ Other, specify __________________________
   What was the diagnosis? (Check all that apply):
   □ Migraine □ Tension-type □ Cluster □ Other, specify __________________________

17. List all past tests you had for your migraine headaches: □ MRI Brain/Neck/Both (circle: Brain / Neck / Both)
   □ MRI w/contrast □ MRI w/o contrast □ CT Scan □ EEG □ Sleep Study □ Other: __________________________
   When/How long ago: ________________________________________________________________

18. List all past treatment(s) for your migraine headaches:
   □ Botox □ Nerve Block □ IV Meds □ Medication
   Other Preventatives: ________________________________________________________________

19. Have you had Botox to treat your migraines in the past? □ No □ Yes - If so, how many treatments did you receive and what was the dosage? _______________
   What kind of relief did you get? □ Complete □ Partial □ None
   How long did the relief last? ______________________

20. Which Medications are or have you taken?

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21. Are you taking any over-the-counter drugs to treat your migraine headaches? □ No □ Yes - If "yes", list the medications under the "Other List" column above and how many times in the last month have you used the over-the-counter medications?
   ________________________________________________________________________________

22. Have you been treated for a psychiatric condition, if so what condition and when was the last treatment?
   ________________________________________________________________________________

23. Have you had hormone or vitamin levels checked? □ No □ Yes - If "yes", list when and the results.
   ________________________________________________________________________________

24. Have you been treated for sinus or other related issues such as deviated septum? □ No □ Yes - If "yes", list the treatment provided.
   ________________________________________________________________________________

25. Do you have numbness or tingling in the hands and/or neck? □ No □ Yes
   ________________________________________________________________________________

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
   ________________________________________________________________________________

28. Have you suffered from a head trauma or injury? □ No □ Yes - If "yes", state the nature of the injury, when the injury occurred and treatment provided.
   ________________________________________________________________________________

29. Have you been diagnosed with or had the following treatments within the past year? If so when/how often?
   □ Eye exam □ TMJ □ Snore □ Wear mouth guard □ Wake up w/migraine □ Wear CPAP □ Have seizures □ Other
   ________________________________________________________________________________

30. List any other medical condition, injury or concern not previously asked above that you feel we should know about.
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________