

# Pre Treatment Migraine Headache Questionnaire



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

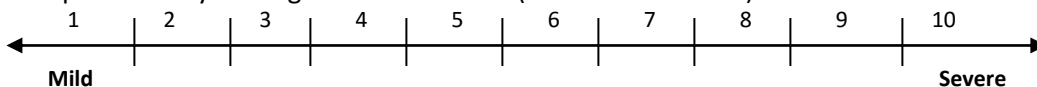
1. How many migraine headaches do you experience per month? \_\_\_\_\_ on average.

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)



6. Where is your migraine headaches **usually** located? (Circle all that apply and indicate which area hurts the most.)

- |   |       |      |      |  |
|---|-------|------|------|--|
| <input type="checkbox"/> Above/Behind the Eye   | Right | Left | Both | <input type="checkbox"/> Other areas: _____              |
| <input type="checkbox"/> Temporal Area          | Right | Left | Both |  |
| <input type="checkbox"/> Occipital/Back of Head | Right | Left | Both | <input type="checkbox"/> 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)

<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Bothered by light/noise	<input type="checkbox"/> Blurred/double vision	<input type="checkbox"/> Sparkling, flashing, or colored lights
<input type="checkbox"/> Eyelid puffy	<input type="checkbox"/> Eyelid droops	<input type="checkbox"/> Loss of vision
<input type="checkbox"/> Feeling lightheaded	<input type="checkbox"/> Numbness / tingling	<input type="checkbox"/> Weakness of arm or leg
<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Speech difficulty	<input type="checkbox"/> Loss of consciousness
<input type="checkbox"/> Runny nose	<input type="checkbox"/> Other _____	

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

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

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

- |   |                                      |   |
|---|--------------------------------------|---|
| <input type="checkbox"/> Rest                                 | <input type="checkbox"/> Exercise    | <input type="checkbox"/> Quiet and darkness |
| <input type="checkbox"/> Hot or cold compress                 | <input type="checkbox"/> Massage     | <input type="checkbox"/> Warm shower        |
| <input type="checkbox"/> Pressure over migraine headache area | <input type="checkbox"/> 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. 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?

Abortive	Past	Current	Preventative	Past	Current	Other - List	Past	Current
Triptan			Topomax					
Maxalt			Valproic Acid					
Relpax			Amitriptyline					
Amerge			Topiramate					
Zomig			Beta Blockers					
Imitrex			Inderal					
Frova			Lopressor					
Axert			Propanolol					
Treximet			Anti-Depressants					
Fiorinal/Florocet			Other Blood Pressure					
Ergots			Other Anti-Depressants					

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.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_