Pre Treatment
Migraine Headache Questionnaire

Name____ Date ___________________________________

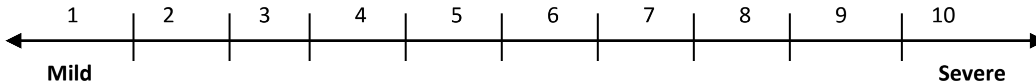
1. How many migraine headaches do you experience per month? __________________________on average.

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)



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
☐ Temporal Area	Right	Left	Both
☐ 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
- ☐ Bothered by light/noise
- ☐ Eyelid puffy
- ☐ Feeling lightheaded
- ☐ Difficulty concentrating
- ☐ Runny nose
- ☐ Vomiting
- ☐ Blurred/double vision
- ☐ Eyelid droops
- ☐ Numbness / tingling
- ☐ Speech difficulty
- ☐ Other____
- ☐ Diarrhea
- ☐ Sparkling, flashing, or colored lights
- ☐ Loss of vision
- ☐ Weakness of arm or leg
- ☐ Loss of consciousness

11. Do any of the following bring on your migraine headaches or make them worse? (Check all that apply)
- ☐ Stress (worry, anger)
- ☐ Letdown" after stress
- ☐ Air travel
- ☐ Missed meals
- ☐ Certain foods (chocolate, cheese, beer, MSG)
- ☐ Bright Sunshine
- ☐ Loud noise
- ☐ Fatigue
- ☐ Sexual activity
- ☐ Weather change
- ☐ Heavy lifting
- ☐ Certain smells or perfume
- ☐ Coughing, straining, bending over
- ☐ Other ____

12. Do any of the following make your migraine headaches better?
- ☐ Rest
- ☐ Hot or cold compress
- ☐ Pressure over migraine headache area
- ☐ Exercise
- ☐ Massage
- ☐ Quiet and darkness
- ☐ Warm shower
- ☐ 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.
____
____
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