

MIGRAINE/HEADACHE QUESTIONNAIRE
PLEASE PRINT

Name: _____ **Date:** _____

1) **AGE:** How old were you when you had your first migraine headache? _____
a) For Females: Was it with onset of menstruation (period)? _____
b) Was there any specific event that occurred that you could relate to the onset of
migraines, or did it come on gradually?

2) **PAST HISTORY:**
a) Does anyone else in your family (i.e. mother, father, grandparents, or other family
members) have migraine headaches?

b) Have you ever been formally evaluated for your headaches? _____
i) If yes, By whom and when? _____
ii) Was the doctor a neurologist? _____. If not, indicate what type of specialist
diagnosed your migraine. _____
iii) Did you ever have a CT scan or MRI scan of your head? _____
---If yes, what were the results?

c) Over the past 5 years, have your headaches worsened? Stayed the same? Improved?

d) Do you get chronic daily headaches or tension headaches in addition to
migraines? _____. If yes, please describe.

3) **FREQUENCY:** How many times per month do you get a migraine headache?

4) **DURATION:** How long does your headache last (in days)? _____
5) **SEVERITY:** On a scale of 1-10 (with 10 being the worst), how would you rate your
headache pain? _____

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6) **DISTRIBUTION**: Please describe specifically where on your body you typically get the headache pain? For example: Is the pain on one side or both sides of your head? Where does it usually start? Does it shift from side-to-side? Is it found behind your eyes? Does the pain distribution also include your neck?

7) Please describe any other specific or unusual details that might characterize your headache.

8) **AURA**: Definition: An aura is a “feeling of disconnection” **prior to** an actual migraine headache. Do you typically experience an aura before your migraine headaches? ____
If yes, please describe:

9) **ASSOCIATED SYMPTOMS**: Please indicate whether you experience the following Symptoms when you get migraine headache pain (yes or no):

- a) Nausea? _____
- b) Vomiting? _____
- c) Photophobia (sensitivity to light)? _____
- d) Phonophobia (sensitivity to sound)? _____
- e) Please describe any other associated symptom(s) that you may experience during a migraine headache:

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10) MEDICATIONS AND TREATMENTS:

a) Please list all current medications that you take for migraine headaches. Also list any side effects you may be experiencing from use of this medication(s).

b) Please list all medications that you have taken in the past that for any reason you are now unable to take, or which were not effective. Please list any side effects you may have experienced.

c) Do you currently take the drug IMITREX or similar type drug? _____. If so, does it relieve your headache? _____. How long does this drug provide relief (in hours)? _____. How long have you been taking Imitrex (or any similar drug)? _____. Do you find Imitrex (or similar drug) to be: a) more effective; b) less effective; or c) just as effective now as when you first began taking the medicine? _____. What side effect do you experience with Imitrex or similar type drug?

d) Other than medication, are there any other treatments (i.e. acupuncture or homeopathic remedies) that you use to help relieve your migraine headache pain? (Yes or No) _____. If yes, please describe:

f) What do you do if medications do not relieve your headache?

Headache questionnaire

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11) JOB/ LIFESTYLE:

a) If currently employed, approximately how much time (hour/month on average) do you miss from work?

b) How do migraine headaches affect planning for your daily activities?

c) How do migraine headaches affect your overall life?

12) OTHER MEDICAL HISTORY:

a) Do you have any other medical problems?
(Please list)

13) PLEASE LIST ALL MEDICATIONS TAKEN:

<u>Name of Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Date started</u>	<u>Prescriber</u>
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14) ALLERGIES:

15) PAST SURGERIES AND DATES:

Headache questionnaire

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