MASSACHUSETTS GENERAL HOSPITAL

Pre-Treatment Migraine Headache Questionnaire

Name: _____ Date: _____

Telephone (H): _____ Telephone (secondary):_____

Date of Birth:_____ ☐ Female ☐ Male

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ Caucasion ☐ Afr.Amer ☐ Hispanic ☐ Other _____

Occupation: _____ Health Insurance Co: _____

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? (Check one)

☐ No more than 2 hours ☐ 3-4 hours ☐ 5-12 hours ☐ 12-24 hours ☐ Several days 1 week or longer

How long do your migraine headaches usually last if you do not take your migraine medicine? (Check one)

☐ No more than 2 hours ☐ 3-4 hours ☐ 5-12 hours ☐ 12-24 hours ☐ Several days 1 week or longer

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

1 2 3 4 5 6 7 8 9 10

Mild Severe

5. 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

6. How old were you when your migraine headaches started?_____

7. How would you describe your migraine headaches? (Check all that apply)

☐Throbbing/pounding ☐Ache/pressure ☐Like a tight band ☐Dull ☐Other

8. Do your migraine headaches awaken you at night?

☐Never ☐Occasionally ☐Often

9. 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_____		

10. 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 _____

11. 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 _____

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. Have your migraines been treated with Botox?

☐No ☐Yes If "yes", when, where, and by whom?_____

18. Did the Botox treatment work? ☐No ☐Yes If "yes," for how long: _____

19. What site was the Botox injected? _____

20. List all past tests you had for your migraine headaches: _____

_____

21. List all past treatment(s) for your migraine headaches: _____

_____

22. 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?_____

23. 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? _____

24. What is your estimated cost per month of your migraine headache medications and visits to the physician?

_____

25. How much of these medical expenses are covered by your health insurance? _____

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