LONG ISLAND PLASTIC SURGICAL GROUP, PC

Pre Treatment
Migraine Headache Questionnaire

Name			**Date**		
(H) Tel			**(W) Tel**		
Date of Birth			☐Female	☐Male	
Marital Status:	☐Married	☐Single	☐Divorced	☐Widowed	
Race:	☐Caucasian	☐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?

☐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?

☐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? (Check one number)

Mild ← ☐1 ☐2 ■3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 → **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 difficult	☐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 ☐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. List all past tests you had for your migraine headaches:

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

19. 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?

20. 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?

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

22. How must of these medical expenses are covered by your health insurance?

23. How would you rate your general health in the last month? (Check one)

☐Excellent ☐Good ☐Fair ☐Poor

24. To what extent do your migraine headaches affect your quality of life? (Check one)

☐Extremely ☐Moderately ☐Very little ☐Not at all