THE MIGRAINE INSTITUTE

PRE-TREATMENT MIGRAINE SURVEY

1) How old were you when your migraine headaches started? _____

2) How many MIGRAINE headaches do you experience per month (on average)? _____

3) How many NON-MIGRAINE headaches do you experience per month (on average)? ____

4) How long do your migraine headaches typically last:

   WITH medication: _____
   WITHOUT medication: _____

5) How painful are your MIGRAINE headaches (1 = minimal pain, 10 = worst pain you can imagine)

   With medication (circle one): [1 2 3 4 5 6 7 8 9 10]
   Without medication (circle one): [1 2 3 4 5 6 7 8 9 10]

6) Where do your migraine headaches typically start? (check all that apply):

BEHIND EYE(S)
☐ RIGHT ☐ LEFT ☐ BOTH

SIDE(S) OF HEAD (temples)
☐ RIGHT ☐ LEFT ☐ BOTH

ABOVE EYEBROW(S)
☐ RIGHT ☐ LEFT ☐ BOTH

BACK OF HEAD
☐ RIGHT ☐ LEFT ☐ BOTH

OTHER (please describe) _____
_____
_____

7) If you were to describe the pain of your migraine headaches, what words would you use? (check all that apply):

☐ Throbbing/Pounding ☐ Pressure/Ache
☐ Like a vice grip/band ☐ Dull

□ Other (please describe) _____

8) Do your migraines ever wake you up at night?

□ Yes □ No

9) What symptoms occur before/during your migraine (check all that apply)?

□ Nausea/Vomiting □ Diarrhea □ Bothered by light
□ Bothered by noise □ Changes in vision □ Seeing lights/flashes
□ Bothered by light □ Puffy eye(s) □ Droopy eye(s)
□ Bothered by noise □ Changes in vision □ Seeing lights/flashes
□ Lightheadedness □ Numbness/tingling □ Muscle weakness
□ Difficulty speaking □ Loss of consciousness □ Runny nose
□ Other _____

10) What can cause your migraine or make it worse (check all that apply)?

□ Stress □ Bright Light □ Change in weather
□ Loud noise □ Physical Activity □ Heavy Lifting
□ Air travel □ Exhaustion/Fatigue □ Smells/Perfume
□ Excess Sleep □ Hunger/Missed Meals □ Sexual activity
□ Coughing/Straining □ Bending over □ Certain foods
□ Other _____

11) What, if anything, makes your migraine better?

□ Sleep/Rest □ Physical Activity □ Quiet
□ Darkness □ Hot compress □ Cold compress
□ Massage □ Warm shower
□ Applied pressure over certain areas
□ Other _____

12) FEMALES ONLY – do your migraines change with any of the following? (check all that apply)

□ Mentrsual cycle □ Birth Control Pills □ Pregnancy □ Hormonal medications

13) Does anyone in your immediate family have migraines?

□ No □ Yes If yes, whom_____

14) Have you ever had an injury to your head or neck requiring medical or surgical care?

□ No □ Yes If yes, what_____

15) Have you been evaluated by a neurologist?

□ No □ Yes

If yes:

Whom_____

What was the diagnosis?

□ MIgraine □ Tension □ Cluster □ Sinus
□ Other_____

16) What past tests have you had for your migraines?

□ MRI
Most recent date _____
Most recent result _____

□ CAT (Cat) Scan
Most recent date _____
Most recent result _____

□ EEG
Most recent date _____
Most recent result _____

□ Other _____
_____
_____

17) Are you currently taking, or have you taken, PRESCRIPTION medications to treat your migraine headaches?

□ No □ Yes

If yes, please list current medications _____
_____
_____

18) In general, what are the side effects of these medications?

□ Severe □ Moderate □ Minimal □ None at all

19) Are you taking OVER-THE-COUNTER medications to treat your migraine headaches?

□ No □ Yes

If yes, please list current medications _____
_____
_____

20) What ALTERNATIVE THERAPIES do use to treat your migraine headaches?

□ NONE

□ Massage □ Acupuncture □ Meditation
□ Other _____

21) Have you previously had Botox performed for your migraine headaches?

□ No □ Yes

If yes, please answer the following:

- How long have you been treated with Botox? _____
- Who has performed your Botox?

  □ Neurologist □ Plastic Surgeon □ Dermatologist
  □ Other _____

- To what areas have you had Botox injected?

  □ Between eyes □ Over forehead □ Sides of head (Temples) □ Back of neck
  □ Other _____

- How effective was the Botox?

  □ Extremely □ Moderately □ Minimally □ No effect

22) Have you tried NASAL SPRAYS for treatment of your migraines?

□ No □ Yes

If yes:

Which one(s)? _____

How effective was the nasal spray?

□ Extremely □ Moderately □ Minimally □ No effect

23) Please estimate your total MONTHLY cost of your migraine treatments, including cost of medications, treatments, doctor visits and other related treatments?

$_____

24) Please estimate the total amount of this costs covered by insurance?

$_____

25) What is the effect of your migraine headaches on your quality of life? (Check one)

□ Severe □ Moderate □ Minimal □ None at all