ISAAC SPINE, JOINT & PAIN INSTITUTE, PLLC

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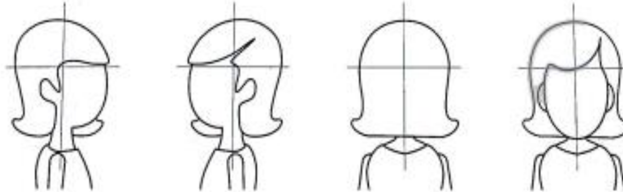
Pre-Treatment Migraine Headache Questionnaire

Name ________________________________Date __________________________

Headache/Migraine Location

1. Place an **X** on the images below to indicate where your headaches/migraines **originate most frequently**. (Mark all that apply.)



1. **How many migraine headaches do you experience per month?** on average ( ).

2. How many total days do you have headaches (ANY TYPE OF HEADACHE) per month?
__________________on average.

3. How long do your migraine headaches usually last (on average) if you do not take your migraine medicine?

□ No more than 2 hours □ 3-4 hours □ 5-12 hours □ 12-24 hours □ (days)

4. **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 □ (days)

5. **How painful are your migraine headaches?** (on scale 1-10) -----------

6. **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

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 How often? __________________

10. **Do any of the following occur before or during your migraine headaches?** (Check all that apply)

□ Nausea □ Vomiting □Runny nose
□ Bothered by light/noise □ Diarrhea □ Blurred/double vision
□ Sparkling, flashing, or colored lights □ Loss of vision
□ Eyelid puffy □ Eyelid droops □ Numbness/ tingling
□ Feeling lightheaded □ Difficulty concentrating
□ Speech difficulty □ Loss of consciousness
□ Weakness of arm or leg □ Other ___________

11. **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 ___________________________________

12. **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 ______________________

13. **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

14. **Do any of your family members have migraine headaches?**

□ No □ Yes
If "yes", explain (who): ____

15. **Have you ever had a head or a neck injury requiring medical treatment?**

□ No· □ Yes
If "yes", describe: ____

16. **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: ____

17. **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 ____

18. **Have your migraines been treated with Botox?**

□ No □ Yes

If "yes", when, where, and by whom?________________________________

Did the Botox treatment work?

□ No □ Yes

If "yes", for how long: ________________________________

19. **What site was the Botox injected? How many Units? (100-200-300)**

____

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

□ Extremely □ Moderately □ Very little □ Not at all

Circle any medications below that you have tried for your migraines:

Aspirin, Ibuprofen (Advil, Motrin IB), **Acetaminophen** (Tylenol)
Excedrin Migraine -(combination of acetaminophen, aspirin and caffeine)
Fioricet / Fiorinal / Esgic - (combination meds containing butalbital, caffeine, and acetaminophen)
Ketorolac (Toradol)

Triptans

- Sumatriptan (Imitrex)
- Rizatriptan (Maxalt)
- Almotriptan (Axer!)
- Naratriptan (Amerge)
- Zolmitriptan (Zomig)
- Frovatriptan (Frova)
- Eletriptan (Relpax)

Combination of sumatriptan and naproxen sodium (Trex1met)

Ergots (Ergotamine and caffeine combination drugs)

- Migergot
  - Cafergot
  - Dihydroergotamine (D.H.E. 45, Migranal)

Anti-seizure medications (Topamax**,** Gabapentin)

Antidepressants (Nortriptyline)

Anti-nausea medications Promethazine (phenergan), Chlorpromazine (Thorazine), metoclopramide (Reglan), prochlorperazine (Compro)

Opioid medications

- Tramadol - Percocet - Lortab

CGRP medications: Ubrelvy, Nurtec, Qulipta, Zavzpret

Glucocorticoids: Steroids

Subcutaneous Injections: Aimovig, Emgality, Ajovy

IV infusion: Ketamin, Vyepti

OTHER MEDICATIONS: ____