UT Southwestern Medical Center

Migraine Headache Questionnaire
Pre-treatment

Pt. Name:_____
Address:_____
_____
City State Zip
MRN: _____
DOB: _____
SSN: XXX-XX-___ ___ ___ ___ SEX:_____
DOS: _____

Name: _____ Date: _____

Occupation: _____ Insurance Company: _____

Do you have a neurologist? ☐ No ☐ Yes (specify): _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced/Separated ☐ Widowed

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To what extent do your migraines impact your life? ☐ No impact ☐ Somewhat impact ☐ Significantly impact

On average, how many migraine headaches do you experience per month? _____

On average, how many regular/non-migraine headaches do you experience per month? _____

How many days per month do you miss work or school due to migraine headaches? _____

Duration of migraines

	> 2 hours	3-5 hours	6-9 hours	10-15 hours	16-24 hours	24 hours +
If you take medication at onset	○	○	○	○	○	○
If you do not take medication	○	○	○	○	○	○

On average, how painful are your migraine headaches?

	Mild	2	3	4	5	6	7	8	9	Severe
Pain scale	○	○	○	○	○	○	○	○	○	○

Where do your migraine headaches typically start?

	Behind eye	Above eyebrow	Temple	Back of head
Left	○	○	○	○
Right	○	○	○	○

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

☐ Throbbing/pounding ☐ Ache/pressure ☐ Tight band ☐ Dull ☐ Other

Do your migraine headaches awaken you at night?

☐ Never ☐ Occasionally ☐ Often

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

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

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Do any of the following bring on your migraine headaches or make them worse? (Check all that apply)

☐ Stress (worry, anger)
☐ Air travel
☐ Missed meals
☐ Certain foods
(e.g. chocolate, beer, cheese, MSG)
☐ Letdown after stress
☐ Bright sunshine
☐ Loud noise
☐ Fatigue
☐ Sexual activity
☐ Weather change
☐ Heavy lifting
☐ Certain smells or perfumes
☐ Coughing, straining, bending over
☐ Other: _____

Do any of the following make your migraine headaches better?

☐ Rest
☐ Massage
☐ Hot or cold compress
☐ Exercise
☐ Pressure over migraine area
☐ Loud noise
☐ Quiet and darkness
☐ Warm shower
☐ Other: _____

If you are female, do your migraine headaches change with the following? (Check all that apply)

☐ Menstrual periods
☐ Birth control pills
☐ Other hormone medication
☐ Pregnancy

Do any of your family members have migraine headaches? ☐ No ☐ Yes (specify)_____

Have you ever been diagnosed with other headache disorders?

☐ Occipital Neuralgia
☐ Tension-type Headache (TTH)
☐ New Daily Persistent Headaches
☐ Pseudotumor Cerebri
☐ Cluster Headache
☐ other (specify):

Have you had any of the following diagnostic tests for your migraines?

☐ MRI of head
☐ MRI of neck
☐ Spinal tap
☐ other (specify): _____
☐ CT of sinus

Have you ever had any of the following?

	No	Yes	Did it help?	In what area of your head did you get this?
Nerve block	☐	☐		
Botox or other injection	☐	☐		
Nerve stimulation	☐	☐		
Radio Frequency Ablation (RFA)	☐	☐		

Have you ever had treatment for any of the following?

	No	Yes	What treatment?	Who was your physician or surgeon?
TMJ problems	☐	☐		
Sinus surgery	☐	☐		
Head or neck injury	☐	☐		
Head or neck surgery	☐	☐		

Do you suffer from depression or anxiety due to migraines? ☐ No ☐ Yes

If yes, have you ever seen a therapist or psychiatrist for this? ☐ No ☐ Yes (name) _____