



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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Stress (worry, anger)                        | <input type="checkbox"/> Bright Sunshine | <input type="checkbox"/> Weather change                    |
| <input type="checkbox"/> Letdown" after stress                        | <input type="checkbox"/> Loud noise      | <input type="checkbox"/> Heavy lifting                     |
| <input type="checkbox"/> Air travel                                   | <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Certain smells or perfume         |
| <input type="checkbox"/> Missed meals                                 | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Coughing, straining, bending over |
| <input type="checkbox"/> Certain foods (chocolate, cheese, beer, MSG) |  | <input type="checkbox"/> Other _____                       |

12. Do any of the following make your migraine headaches better?

- |  |                                   |   |
|--|-----------------------------------|---|
| <input type="checkbox"/> Rest          | <input type="checkbox"/> Exercise | <input type="checkbox"/> Quiet and darkness                   |
| <input type="checkbox"/> Hot compress  | <input type="checkbox"/> Massage  | <input type="checkbox"/> Warm shower                          |
| <input type="checkbox"/> Cold compress |                                   | <input type="checkbox"/> Pressure over migraine headache area |

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

- |  |  |                                    |   |
|--|--|------------------------------------|---|
| <input type="checkbox"/> Menstrual periods | <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> 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. List all past tests you had for your migraine headaches: \_\_\_\_\_

19. List all past treatment(s) for your migraine headaches: \_\_\_\_\_

20. 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? \_\_\_\_\_

21. 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? \_\_\_\_\_

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

23. How much of these medical expenses are covered by your health insurance? \_\_\_\_\_

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

- Excellent  Good  Fair  Poor

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

- Extremely  Moderately  Very little  Not at all