

Associated Headache Symptoms:

• Are any of the following symptoms associated with the headache? Please mark: (B) before (X) during (A) after

- Spots before eyes - type - Blindness (R / L) Blurring (R / L) Eyelid droop (R / L)
- Can see only half of objects Tearing (R / L) Double Vision Eye redness (R / L)
- Eyes puffy (R / L) Light sensitivity Noise sensitivity Odor sensitivity
- Nose blocked / discharge (R / L)

- Nausea Vomiting Stomach Cramps Hunger
- Loss of appetite Diarrhea

Face - Scalp -

- Pale Redness Sweating Tender
- Pain on chewing Puffy Decreased jaw opening

Neck -

- Stiff Tender

- Depression Fatigue Anxiety Irritability
- Difficulty concentrating Difficulty talking (finding words) Difficulty understanding
- Fainting (feel like or have fainted) Slurred speech Dizzy (lightheaded - unsteady - Spinning)

Hands and / or feet -

- Cold Pale Sweaty Mottled

Weakness(W) Numbness(N) Both(B)

- Face(R / L) Arms(R / L) Legs(R / L) Arm & Leg (R / L)
- Numbness around lips

Indicate if any of the following factors have (+) brought on (trigger) or (++) worsen your headache -

- Sleep - too much - too little Sexual activity Chocolate Medications(list)
- Emotional stress - during - after Missed meal Citrus fruits Menstrual Periods
- Depression - anxiety Change in weather Cheeses Pregnancy
- Physical activity Seasons - MSG Menopause
- Erect Position Alcohol Other foods(list) Oral Contraceptives
- Bending Over Processed meats Straining - coughing

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Which over-the-counter medications have you taken for your headaches

Do you use them each day? _____ If so 1-2 3-4 5 or more

How well do they work _____

Have you noticed an increase in the frequency of your headaches when you increase your medications? YES NO

List all prescription meds you have you taken/tried for your headaches:

Preventive meds. _____

Pain relief _____

Which seem to work _____

How frequently do you take them _____

Migraine Disability Questionnaire (MIDAS)

1. Complete questions 1-5 for ALL your headaches during the last 3 months. Write 0 in the box if you did not experience any problem asked.
2. Add up the answers to questions 1-5.
3. Answer questions A and B.

1. How many days in the last 3 months did you miss work or school because of your headaches? _____

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of headaches (do not include days counted in #1)? _____

3. How many days in the last 3 months did you not do housework because of your headaches? _____

4. How many days in the last 3 months was your productivity in housework reduced by half or more? _____

5. How many days in the last 3 months did you miss family, social, or leisure activities because of your headaches? _____

MIDAS Score Total _____

A. How many days in the last 3 months did you have a headache? _____

B. On a scale of 1-10, on average, how painful are you headaches? _____