Headache Questionnaire

At what age did you have your first headache: ___________   What year did your current headaches begin: ___________
When was your last headache: ____________________________________________________________
Are you ever free of pain completely? □ Yes □ No
Do you have more than one type of headaches? □ Yes □ No
If yes, describe them separately: __________________________________________________________________________

How many headaches (any type) do you have each month: ___________, how long do they last: ___________
How would you describe the pain of your most serious headaches (circle one or several):

throbbing    pulsating    dull    aching    pressure-like

sharp    stabbing    electric-like    vise-like

Does the pain like: □ going from outside - in (compressing, stabbing) □ from inside - out (exploding, pushing out)
When you have a headache (and possibly after), does your scalp and face become sensitive to touch and do you avoid putting on glasses, jewelry or combing your hair? □ Yes □ No
Are your headaches brought on by:

your periods / hormonal changes    exercise    stress    relaxation after stress    change in weather
alcohol    bright light / glare    odors    smoke    noise    lack of sleep    too much sleep    hunger
food additives    certain foods

Do your headaches occur on any particular day of the week or time of day? ______________________________________
____________________________________________________________________________________________________

Do you have any warning signs before the start of a headache? □ Yes □ No
Describe: _____________________________________________________________________________________________

Circle any of the following symptoms you have with your headaches:

neck pain    nausea    vomiting    light sensitivity    dizziness    noise sensitivity    numbness
weakness    fever    confusion    difficulty speaking    tearing    nasal congestion    eyelid drooping
worsening of pain with movement    other: ______________________________________________________________

Please indicate with X's where you experience pain:
Have you ever been treated for headaches?  Yes  No

What kind of headaches were you told you have: _____________________________________________________________

Have you had any tests done to diagnose your headaches?  Yes  No

Describe: ______________________________________________________________________________________________

Which of the following medicines have you tried for your headaches (of any kind) (circle):

- Anaprox
- Codeine
- Imitrex / Sumatriptan
- Percogesic
- Aspirin
- Darvon / Darvocet
- Inderal / Propranolol
- Phrenilin Forte
- Anacin
- Dexamethasone / Decadron
- Indocin / Indomethacin
- Relpax
- Advil / Ibuprofin
- Decongestants
- Lamictal
- Robaxin
- Aleve / Naproxen
- DHE-45
- Lidocaine
- Timolol
- Amerge
- Demerol
- Lithium
- Toprol / Toprol XR
- Axert
- Depakote
- Lyrica
- Topamax / Topiramate
- Amitriptyline / Elavil
- Desyrel / Tradozone
- Maxalt
- Tylenol
- Atacand
- Dilantin / Phenytoin
- Metoprolol
- Ultram / Tramadol
- Benicar
- Effexor
- Migralex
- Ultracet
- Beta-blockers
- Esgic
- Migranal
- Valium
- Botox
- Excedrin
- Motrin / Ibuprofin
- Vivactyl / Protriptyline
- Bufferin
- Fioricet / Butalbital
- Neurontin / Gabapentin
- Xanax
- Cafergot
- Fiorinal / Butalbital
- Naprosyn / Anaprox
- Zanaflex
- Calan / Verapamil
- Flexeril
- Pamelor / Notriptyline
- Zecuity
- Cymbalta
- Frova
- Percocet / Oxycodeone
- Zornig
-  
- Percodan
- Zonegran
- Other:

*Star those which helped, even for a while.

Have you tried any of the following alternative treatments (circle):

Biofeedback  Acupuncture  Chiropractic  Physical Therapy  Other: ____________________________

Supplements: (Feverfew, B2, Magnesium, Migrelief, CoQ10, Butterbur, Petadolex)

List all the headache medications and the amounts you are now taking (over the counter or prescribed):

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List all other medications you are taking for any reason:

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HEADACHE QUESTIONNAIRE

MIDAS QUESTIONNAIRE | MIGRAINE DISABILITY ASSESSMENT

Patient Name: ___________________________________________________  Date: ______________________________

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you.

INSTRUCTIONS: Please answer the following questions about all of your headaches over the last 3 months. Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months.

1. On how many days in the last 3 months did you miss work or school because of your headaches? (if you do not attend work or school enter zero in the space to the right).

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school. If you do not attend work or school, enter zero in the space to the right).

3. On how many days in the last 3 months did you not do household work because of your headaches?

4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school. If you do not attend work or school, enter zero in the space to the right).

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

A. On how many days in the last 3 months did you have a headache? (If headache lasted more than 1 day, count each day.)

B. On a scale of 0-10, on average, how painful were these headaches? (0 = no pain at all, and 10 = pain which is as bad as it can be.)

Add the total number of days from questions 1 to 5 (ignore A and B).

During the past month:

1) Have you been bothered a lot in the last month by feeling sad, down, or depressed?  ☐ Yes  ☐ No

2) Have you been bothered a lot in the last month by a loss of interest or pleasure in your daily activities?  ☐ Yes  ☐ No

For Men: When was the last time you had more then five drinks in one day?

☐ Never  ☐ In the past three months  ☐ Over three months ago

For Women: When was the last time you had more then four drinks in one day?

☐ Never  ☐ In the past three months  ☐ Over three months ago
Headache Questionnaire

Have you had any of the following problems in the past 6 months:

- Change in marital status
- Change in job / school
- New illness diagnosed
- Emotional trauma
- Change in smoking / drinking / diet
- Hospitalizations / surgery
- Fatigue
- Bruising
- Weight change; loss _____ lbs, gain _____ lbs
- Allergic reaction
- Skin rash
- Fever / chills
- High blood pressure
- Palpitations
- Breathing difficulty
- Chest pain
- Swelling
- Chronic cough
- Wheezing
- Bleeding / bruising
- Diarrhea
- Constipation
- Heartburn
- Stomach pain
- Nausea / vomiting
- Joint pain / swelling / redness
- Muscle aches
- Sexual dysfunction
- Breast lumps / discharge
- Symptoms of menopause
- Irregular periods
- PMS
- Bladder problems
- Cold extremities
- Leg / foot cramps
- Depression
- Anxiety / panic attacks
- Change in skin / hair
- Excessive urination or thirst
- Insomnia
- Leg restlessness
- Daytime sleepiness
- Snoring
- Sleep apnea
- Teeth grinding / clenching
- Seizures / shaking
- Headaches
- Back pain
- Neck pain
- Decline in memory
- Weakness
- Numbness
- Hearing problems
- Vision problems
- Loss of consciousness
- Dizziness
- Dental problems
- Sinus problems
- Hoarseness
- Any other problems not listed
Headache Questionnaire

Please list all of your present medical problems and doctors you are seeing:
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________

Please list all past medical problems, operations, and hospital admissions:
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________

Please list your allergies, if any:
_________________________________________________________________________________________________________________________________________

Height: __________   Weight: __________

Amounts per day:

If you smoke, how much: _________ Recreational Drugs:  □ Yes  □ No

What time do you go to sleep and wake up?  Weekdays: _________ Weekends: _________

Physical exercise / frequency / duration: ______________________________________________________

Present work status: ______________________________ Do you like your job:  □ Yes  □ No  □ Not Sure

If you have children, please list their ages:
________________________________________________________________________________________

Please list hobbies / recreational activities:
________________________________________________________________________________________

What is your current level of stress (0 = no stress, 10 = catastrophic): _________

Level of education: ______________________________ Do you have pets:  □ Yes  □ No

With whom are you living with (list relationship and age): ______________________________________

Are there any serious problems at home:  □ Yes  □ No, if yes describe: ______________________________________

Is there a family history of (check all that apply):
□ Headaches  □ Heart Disease  □ Alcoholism  □ Tuberculosis  □ Excessive Bleeding
□ Seizures  □ High Blood Pressure  □ Goiter/Thyroid  □ Mental Illness  □ Cancer
□ Strokes  □ Arthritis  □ Diabetes  □ Obesity  □ Sleep Disorders
□ Other: __________________________________________________________