Migraine Surgery Intake Questionnaire

Name: Date:

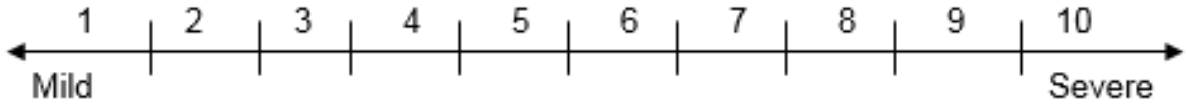
Telephone (Home): Telephone (Work):

Date of Birth: ☐Female ☐Male

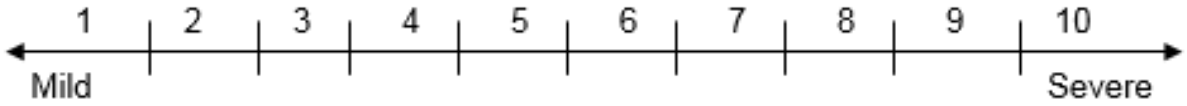
Health Insurance Company:

PCP: Neurologist:

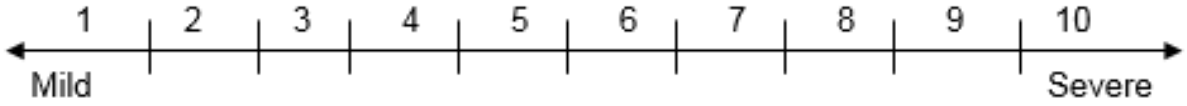
1. How many **migraine** headaches do you experience per month?
2. How many **regular** headaches do you experience per month?
3. How long do your migraine headaches usually last (in hours) ?
4. How painful are your headaches **on average**? (circle one number)



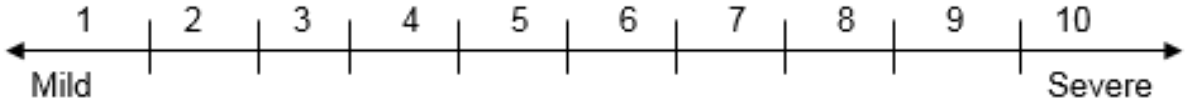
5. What is the **worst** headache that you experience regularly? (circle one number)



6. What is the **mildest** headache that you experience regularly? (circle one number)



7. What is your headache score **today**? (circle one number)



8. Does your headache score actually ever go to zero? ☐ YES ☐ NO

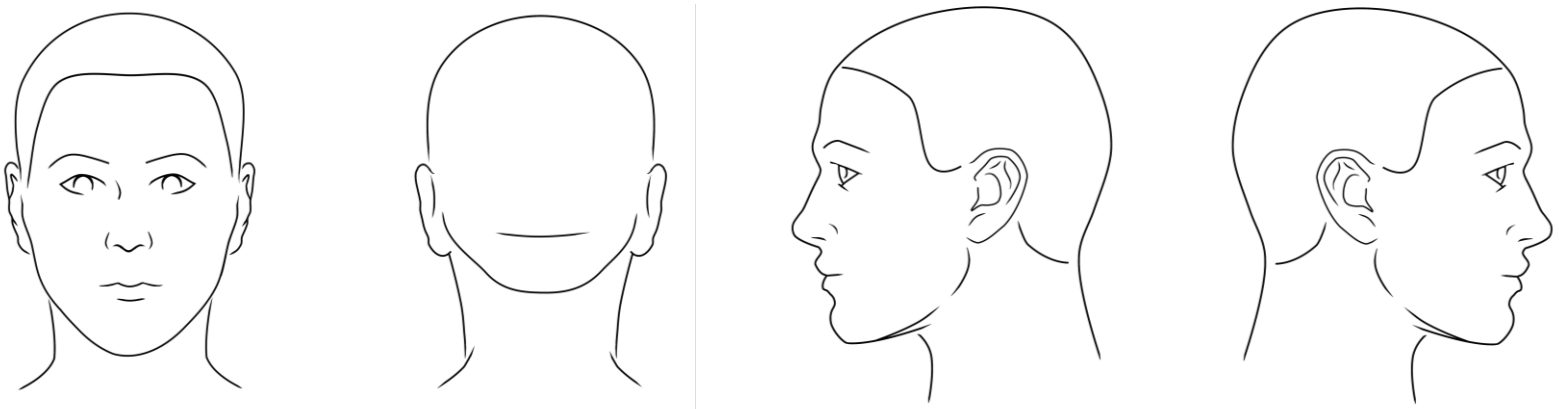
9. On which side of the head is your pain?
   ☐ right side ☐ left side ☐ both sides

10. Is your pain more prominent on the right side, the left side, or equal on both sides?
    ☐ right side ☐ left side ☐ both sides

11. Where do your migraine headaches usually **START**? (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
☐ Nose / center of face ☐ Other: Please describe _____

12. Please draw where the pain starts and where it spreads. Use X for where it starts or is more severe, and arrows for where it spreads.



13. How old were you when your **migraine** headaches started? _____
14. Was there any event that you believe caused/started your migraines?
    ☐ YES ☐ NO
    If yes, what event? _____
15. Have you ever had a **head or neck injury** (e.g. whiplash, concussion)? ☐ YES ☐ NO
    a. If yes, please describe: _____
    _____
16. Do you or one of your physicians suspect that a health disorder is somehow related to your migraine headaches?
    ☐ YES ☐ NO
    a. If yes, please describe: _____
    _____

17. How would you describe the pain associated with your migraine headaches? (check all that apply)

☐ Throbbing or pounding
☐ Aching or pressure
☐ Tightness
☐ Dull pain

☐ Other: _____

18. Do your migraine headaches wake you up at night?

☐ Never

☐ Occasionally

☐ Often

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

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

20. Do any of the following trigger 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: _____

21. 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: _____

22. 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

If yes, have the conditions mentioned above made your migraines better or worse?

☐ Better ☐ Worse

23. a. How many neurologists have you seen for your migraines? _____

Please list their names:

_____

_____

_____

b. What was the diagnosis? (check all that apply)

☐ Migraine ☐ Tension-Headache ☐ Cluster ☐ Occipital Neuralgia ☐ Trigeminal Neuralgia ☐ Chronic Migraine ☐ Episodic Migraine ☐ Cervicogenic Headache

☐ Other: _____

24. Have you had any of the following **radiology studies** performed?

a. MRI (Head): ☐ YES ☐ NO
   i. If yes, date of study: _____
b. MRI (Neck): ☐ YES ☐ NO
   i. If yes, date of study: _____
c. CT Scan (Head/Neck): ☐ YES ☐ NO
   i. If yes, date of study: _____
d. Other ☐ YES ☐ NO
   i. If yes, type and date of study: _____

If you answered yes to any of the radiology studies, please bring copy of reports to your appointment

25. Please list **current** medications you are taking to treat your migraine headaches:

a. Preventative (Prophylactic):

b. Rescue (Abortive):

26. Please check any **past medications** you have taken to treat your migraine headaches:

a. Anti-inflammatory:
   ☐ Aspirin ☐ Advil ☐ Toradol ☐ Tylenol
   ☐ Excedrin ☐ Aleve ☐ Cortisol ☐ Prednisone
   ☐ Dexamethasone ☐ Other: _____
b. Narcotics:
   ☐ Fiorinal ☐ Vicodin ☐ Percocet ☐ Demerol
   ☐ Oxycontin ☐ Oxycodone ☐ Hydrocodone ☐ Fioricet
   ☐ Other: _____
c. Abortive:
   ☐ Cafegot ☐ Relpax ☐ Treximet ☐ Maxalt

☐ Amerge ☐ Frova ☐ Zomig ☐ Midrin
☐ Sumatriptan ☐ Imitrex ☐ Other: _____

d. Preventative:

☐ Propranolol ☐ Timolol ☐ Nadolol ☐ Metoprolol
☐ Atenolol ☐ Verapamil ☐ Diltiazem ☐ Amitriptyline
☐ Nortriptyline ☐ Topiramate ☐ Elavil ☐ Topamax
☐ Clonidine ☐ Feverfew ☐ Dilantin ☐ Depakote
☐ Zoloft ☐ Paxil ☐ Prozac ☐ Effexor
☐ Wellbutrin ☐ Trazodone ☐ Protriptyline ☐ Desipramine
☐ Doxepin ☐ Other: _____

e. Miscellaneous:

☐ Phrenilin ☐ DHE ☐ Baclofen ☐ Gabapentin
☐ Cymbalta ☐ Other: _____

27. Please list any **over-the-counter (OTC)** medications related to migraine that you are currently taking:

_____

_____

_____

_____

28. Have you ever had **Botox** to treat your migraines? ☐ YES ☐ NO

a. Where? ☐ Back of head (occipital region) ☐ Front of head (forehead/brow) ☐ Both
b. Who performed your Botox injections? _____
c. Did your Botox injections help?

☐ no relief (0%)
☐ some relief (<50%)
☐ significant relief (>50%, but not complete)
☐ complete relief (100%)

29. Have you ever had **nerve blocks** to treat your migraines? ☐ YES ☐ NO

a. Where? ☐ Back of head (occipital region) ☐ Front of head (forehead/brow) ☐ Both
b. Who performed your nerve blocks? _____
c. Did your nerve blocks help at the time of the injection (while there was numbness)?

☐ no relief (0%)
☐ some relief (<50%)
☐ significant relief (>50%, but not complete)
☐ complete relief (100%)

30. Have you ever had a **nerve stimulator** to treat your migraines? ☐ YES ☐ NO

a. Where? ☐ Back of head (occipital region) ☐ Front of head (forehead/brow) ☐ Both

b. Who performed your nerve stimulator?

c. Which nerve stimulator was implanted?

d. Did your nerve stimulator help?

☐ no relief (0%)

☐ some relief (<50%)

☐ significant relief (>50%, but not complete)

☐ complete relief (100%)

e. For how many months did the nerve stimulator help?

31. Have you ever had **radiofrequency nerve ablation** to treat your migraines? YES NO

a. Where? ☐ Back of head (occipital region) ☐ Front of head (forehead/brow) ☐ Both

b. Who performed your nerve ablation? _____

c. Did your nerve ablation help?

☐ no relief (0%)

☐ some relief (<50%)

☐ significant relief (>50%, but not complete)

☐ complete relief (100%)

d. For how many months did the nerve ablation help?

32. Have you sought treatment in the emergency room or hospital for your migraine headaches?

☐No ☐Yes – If yes, how many times? _____

33. Please list any other treatment(s) you have received for your migraine headaches:

☐ acupunture

☐ massage

☐ craniosacral therapy

☐ other: _____

34. How much would you estimate your migraine headache medications, appointments, and treatments

35. cost you **per month**? _____

36. How many of these medical expenses would you estimate are covered by your health insurance

37. **per month**? _____

38. To what extent do your migraine headaches affect your overall quality of life? (check one)

- ☐ Completely (unable to do desired activities)
- ☐ Moderately
- ☐ Minimally
- ☐ Not at all (able to do desired activities)

39. Do you have/had any of the following **medical conditions**? (check all that apply)

☐ Diabetes	☐ Heart attack	☐ Stroke
☐ Epilepsy	☐ Hypertension	☐ Hypotension
☐ Depression	☐ Fibromyalgia	☐ Thyroid disorder
☐ Asthma	☐ Lupus	☐ Peripheral neuropathy
☐ Carpal tunnel	☐ Shingles	☐ Cold sores/herpes

☐ Other: _____

40. Please list any previous surgeries you have had and when they took place:

_____

_____

_____

_____

41. What is your approximate consumption of the following:

a. Coffee/Tea/Caffeinated Soda: _____ per day / week / month
b. Alcohol: _____ per day / week / month
c. Tobacco: _____ per day / week / month
d. Other intoxicating/mind altering drugs: _____ per day / week / month

42. Please list any **medication allergies** you have:

_____

_____

43. Do any of your family members have migraine headaches?

☐No ☐Yes – If yes, who? _____

44. Please list any additional information that you feel is important to your medical care/history:

_____

_____