

## Migraine questionnaire<sup>®</sup>

Date: \_\_\_\_\_

**Surname:** \_\_\_\_\_ **First name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Street:** \_\_\_\_\_ **Postcode/City:** \_\_\_\_\_

**Country:** \_\_\_\_\_ **Gender:** m  f

**Occupation:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Health insurance:** \_\_\_\_\_

1. How old were you when you first had a migraine attack?
2. Do you know what caused or triggered it then?
3. Do other members of your family suffer from migraines? If so, who?
4. How many days a month do you have "normal" headaches?
5. How many days a month do you suffer from migraines?
6. How long does your migraine last on average?

< 2 hours

3-4 hours

5-12 hours

12-24 hours

>24 hours

> 1 week

**7. How painful are your migraine attacks?**

(On a scale of 1-10, with 1 being no pain and 10 being excruciating pain)

1	2	3	4	5	6	7	8	9	10
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Please tick all the boxes that apply to you in the following question.

**8. Where do you experience the majority of your migraine-related pain?**

	right	left
<input type="checkbox"/> behind your eye		
<input type="checkbox"/> above your eyebrow		
<input type="checkbox"/> on the temple		
<input type="checkbox"/> on the back of your head		
<input type="checkbox"/> distribution (in %) per side Please estimate a percentage		

**9. During a migraine attack, do you usually experience pressure or pain in the nose?**

always       sometimes       never

**10. Do you or have you ever had sinus problems?**

yes       no

**11. Is your migraine related to changes in the weather?**

always       sometimes       never

**12. Do you wake up at night due to migraine pain?**

never       sometimes       often       always

**13. Have you ever suffered one or more of the following symptoms before or during a migraine attack?**

	<b>before</b>	<b>during</b>		<b>before</b>	<b>during</b>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting combined with diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea (without vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to noise	<input type="checkbox"/>	<input type="checkbox"/>
Watering eyes	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Increased sweating	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of the eyelids	<input type="checkbox"/>	<input type="checkbox"/>	Speech defects	<input type="checkbox"/>	<input type="checkbox"/>
Problems concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Loss of consciousness (fainting)	<input type="checkbox"/>	<input type="checkbox"/>
Numbness in the skin	<input type="checkbox"/>	<input type="checkbox"/>	Increased nasal secretion	<input type="checkbox"/>	<input type="checkbox"/>
Sight disorders (double vision, flashes, zigzag lines, blurred vision, other)	<input type="checkbox"/>	<input type="checkbox"/>	Low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>
			Other symptoms	<input type="checkbox"/>	<input type="checkbox"/>

**14. Do you suffer from increased sensitivity to pain before or during a migraine attack (allodynia)?**

The following questions relate to the pain you experience as part of your migraine. Please tick all the boxes that apply to you:

- My hair 'feels' painful
- I have to wear my hair down or put it up (remove hairclips, hairbands, etc.)
- I no longer use hair curlers/straighteners
- I sometimes let my hair float in the bath to get some relief from my headache
- I have had to cut off my long hair to reduce the weight on my scalp
- The feeling of rain/showers/water falling on my head is painful
- I find it painful to wear anything on my head (e.g. hat)
- Eye shadow is uncomfortable
- I cannot wear headphones during my migraine attack
- During a migraine attack, I find wearing blankets uncomfortable
- My fingers feel painful on contact with everyday items
- My sensitivity to pain has increased over recent years

**15. What gives you relief during a migraine attack??**

- |   |                                     |                                       |
|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rest           | <input type="checkbox"/> Darkness   | <input type="checkbox"/> Music        |
| <input type="checkbox"/> Vomiting       | <input type="checkbox"/> Television | <input type="checkbox"/> Massage      |
| <input type="checkbox"/> Sport/exercise | <input type="checkbox"/> Warm water | <input type="checkbox"/> Reading      |
| <input type="checkbox"/> Sleep          | <input type="checkbox"/> Cold water | <input type="checkbox"/> Pain-killers |

**16. What triggers or exacerbates (worsens) your migraine ?**

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Noise                   | <input type="checkbox"/> Change of weather            | <input type="checkbox"/> Light        |
| <input type="checkbox"/> Physical exertion       | <input type="checkbox"/> Smells                       | <input type="checkbox"/> Stress       |
| <input type="checkbox"/> Irregular or late meals | <input type="checkbox"/> Fatigue (tiredness)          | <input type="checkbox"/> Coughing     |
| <input type="checkbox"/> Certain foods           | <input type="checkbox"/> Too much or too little sleep | <input type="checkbox"/> Pain-killers |

**17. If you are a women, is/was your migraine affected by the following?  
If so, in what way?**

- |   |       |
|---|-------|
| <input type="checkbox"/> Menstruation (monthly periods)         | _____ |
| <input type="checkbox"/> The contraceptive Pill                 | _____ |
| <input type="checkbox"/> Hormone tablets (eg HRT for menopause) | _____ |
| <input type="checkbox"/> Pregnancy                              | _____ |

**18. Have you ever had medical treatment for an injury to your head or neck?**

- |                             |                              |  |
|-----------------------------|------------------------------|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Please provide details of the treatment |
|-----------------------------|------------------------------|--|

**19. Have you ever had one of the following medical problems?**

- |  |                                     |  |
|--|-------------------------------------|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma     | <input type="checkbox"/> Epilepsy          |
| <input type="checkbox"/> Coronary disease    | <input type="checkbox"/> Depression | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Stomach ulcers      | <input type="checkbox"/> Allergy    | <input type="checkbox"/> problems/diseases |

**20. Are you short-sighted or long-sighted?**

- Yes, short-sighted                       Yes, long-sighted

**21. Do you wear**

- Glasses                                       (Hard) contact lenses                       (Soft) contact lenses?

**22. Have you ever been examined and treated by a doctor for your migraines?**

- yes, by a                                       G.P.     orthopaedic surgeon  
     neurologist                                       other (please provide details)
- no

**23. Have you had any of the following tests for your migraine?**

- EEG (electroencephalogram)     Blood tests  
 CT (Computer Tomography)     X-ray  
 MRT     ECG  
 Others:

**24. Which of the following treatments do you mainly take for your migraine?**

**Over-the-counter medicines?**

Which one(s)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Prescription-only medicines?**

Which one(s)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please specify how long you have been taking medication for your migraine

(how many days/months/years)

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How much do you spend each month on medication?

approx. \_\_\_\_\_ EURO

**25. Do these treatments help you?**

- no             somewhat     occasionally     normally     always

**26. How many times did you see a doctor last year about your migraines?**

- none             1-4             5-10             > 10

**27. How many different doctors did you see last year about your migraines?**

- none             1-3             5-8             8-10

**28. Do you do anything to prevent a migraine attack from occurring?**

- Music to relax             Exercise             Administer local pain relief  
(gel, cream etc)
- Muscle relaxation             Complementary medicine     Medication

**29. How many days were you absent from work last year due to migraines?**

- < 3 days     4-7 days     8-14 days     15-21 days     > 3 weeks

**30. Did you have to visit an A&E department or call an emergency doctor last year because of migraine pain?**

- no             yes             how often?

**31. Which of the following approaches have you used in the past?**

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Homoeopathy          | <input type="checkbox"/> Migraine cushions | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Psychotherapy        | <input type="checkbox"/> Hypnosis          | <input type="checkbox"/> Osteopathy  |
| <input type="checkbox"/> Relaxation exercises | <input type="checkbox"/> Herbal remedies   | <input type="checkbox"/> Other       |

If one or more of the above methods has/have helped you, please state how long the improvement lasted in months:

**32. In the past, have you ever had an injection with botulinum toxin type A (commonly marketed as Botox) for cosmetic reasons?**

- no                       yes                       how often?

Please specify the location of the injection:

- |   |  |
|---|--|
| <input type="checkbox"/> between the eyebrows<br>(anger wrinkles) | <input type="checkbox"/> corner of the eyes<br>(laughing wrinkles) |
|---|--|

**33. Please provide any further information about your migraine symptoms or treatment that you think might be relevant:**

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**34. How did you learn about the Migraine Surgery Centre?**

- newspaper / magazine     internet                       television / radio             other patients

Other: \_\_\_\_\_