

Migraine Questionnaire[®]

Date: _____

Surname: _____ First name: _____ Date of birth: _____

Street: _____ Postcode/City: _____

Country: _____ Gender: m f

Occupation: _____ Telephone: _____

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?

	before	during		before	during
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)

How much do you spend each month on medication?

approx. _____ GBP

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 4-7 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
(anger wrinkles) | <input type="checkbox"/> corner of the eyes
(laughing wrinkles) |
|---|--|

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

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

- newspaper / magazine internet television / radio other patients

Other: _____