



Kevin G. Rose M.D.

## Migraine Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  Female  Male  
 Marital Status:  Married  Single  Divorced  Widowed  
 Race:  Caucasian  Afr. American  Hispanic  Other  
 Education Level:  HS Grad  2yr degree  4yr degree  Adv. Degree  
 Occupation: \_\_\_\_\_ Health Insurance Co.: \_\_\_\_\_

1: How many migraines do you have per month?: \_\_\_\_\_

2: How many regular headaches do you have per month?: \_\_\_\_\_

3: How long do your migraine headaches last?: (check One)

No more than two hours  3-4 Hours  5-24 Hours  Several Hours  1 week or longer

4: How painful are your migraine headaches (circle one)

←---1---/---2---/---3---/---4---/---5---/---6---/---7---/---8---/---9---/---10---/---→  
**Mild** **Severe**

5: Where are your migraine headaches located (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 right side  Back of head left side  Back of head on both sides

6: How old were you when your migraine headaches started?: \_\_\_\_\_

7: How would you describe your migraine headaches (check all that apply)

Throbbing/pounding  Ache/pressure  Like a tight band  Other \_\_\_\_\_

8: Do your migraine headaches awaken you at night?

Never  Occasionally  Often

9: 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, lights  
 Eyelid puffy  Eyelid droops  Loss of vision  
 Feeling light headed  Numbness/tingling  Weakness of arm or leg  
 Difficulty concentrating  Speech difficulty  Loss of consciousness  
 Runny nose  Other \_\_\_\_\_

10: Do any of the following bring on your migraine headaches or make them worse? (check all that apply)

Member



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- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Stress (worry, anger)                        | <input type="checkbox"/> Bright sunshine | <input type="checkbox"/> Weather change               |
| <input type="checkbox"/> Letdown after stress                         | <input type="checkbox"/> Loud noises     | <input type="checkbox"/> Heavy lifting                |
| <input type="checkbox"/> Air travel                                   | <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Certain smells or perfume    |
| <input type="checkbox"/> Missed meals                                 | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Coughing, straining, bending |
| <input type="checkbox"/> Certain foods (Chocolate, cheese, beer etc.) |  | <input type="checkbox"/> Other_____                   |

11: Do any of the following make your migraine headaches better?

- |  |                                   |   |
|--|-----------------------------------|---|
| <input type="checkbox"/> Rest                        | <input type="checkbox"/> Exercise | <input type="checkbox"/> Quiet and darkness |
| <input type="checkbox"/> Hot or Cold compress        | <input type="checkbox"/> Massage  | <input type="checkbox"/> Warm shower        |
| <input type="checkbox"/> Pressure over migraine area |                                   | <input type="checkbox"/> Other_____         |

12: If you are female, do your migraine headaches change with the following? (check all that apply)

- |   |  |                                    |                                     |
|---|--|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Menstrual period | <input type="checkbox"/> Birth control | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Other_____ |
|---|--|------------------------------------|-------------------------------------|

13: Do any of your family members have migraine headaches?

- No      Yes    If "yes" explain who\_\_\_\_\_

14: Have you ever had a head or a neck injury requiring medical treatment?

- No      Yes    If "yes" describe \_\_\_\_\_

15: Have you ever been diagnosed to have any health disorder(e.g. high blood pressure, asthma, heart disease, gastric ulcer)?

- No      Yes    If "yes" please list\_\_\_\_\_

16: Have you had your migraine headaches evaluated by a neurologist?

- No      Yes    If "yes", when, where, and by whom?\_\_\_\_\_

\*What was the diagnosis? Migraine      Tension      Cluster      Other\_\_\_\_\_

17: List all past tests you had for your migraine headaches:\_\_\_\_\_

18: List all past treatment(s) for your migraine headaches:\_\_\_\_\_

19: Are you taking any *prescription* drugs to treat your migraine headaches?

- No    Yes    If "yes" list medications:\_\_\_\_\_

\*How many times in the last month have you used the medications?\_\_\_\_\_

20: Are you taking any over the counter drugs to treat your migraine headaches?

- No    Yes    If "yes" please list medications:\_\_\_\_\_

\*How many times in the last month have you used the medications?\_\_\_\_\_

21: What is your estimated cost per month of your migraine headache medications and visits to the physician or emergency room\_\_\_\_\_

22: How much of these expenses are covered by your insurance?\_\_\_\_\_

23: How would you rate your general health in the last month?:

- Excellent    Good      Fair      Poor

24: To what extent do your migraine headaches affect your quality of life?:

- Extremely    Moderately    Very little    Not at all



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25: I understand that, as a migraine patient of The Rose Clinic, I am responsible for payment on my account for migraine treatment including but not limited to Botox injections and surgery. The Rose Clinic does not submit any claim or board review information to insurance companies for Botox or surgery reimbursement.

26: I understand the Dr. Rose is working hand-in-hand with the family practice physician, neurologist or pain management specialist that diagnosed me with migraine headaches and referred me to Dr. Rose. While Dr. Rose may, at his discretion, prescribe medications for a short term following surgery, I understand that any long term need for prescription medications will be the responsibility of the family practice physician, neurologist or pain management specialist that referred me to The Rose Clinic.

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Signature



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