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Post injection migraine questionnaire

Name: _____ Date: _____

Part I

- 1: Following the injection, did you notice an improvement in your migraines? Yes or No
- 2: How many migraines have you had in the last month? _____
3. How many regular headaches have you had in the last month? _____

If your answers to Part I above are "NO" or "0" do not proceed to Part II of questionnaire

Part II

- 1: How long did the migraine headaches last, on average?
No more than two hours 3-4 Hours 5-24 Hours Several Days 1 week or longer
- 2: How painful are your migraine headaches (circle one)
- ←---1---/---2---/---3---/---4---/---5---/---6---/---7---/---8---/---9---/---10---/---→
Mild **Severe**
- 3: Was there a change in the character or location of the migraine headache? No Yes
If "yes" explain _____
- 4: If you are female, was your migraine during the time of your menstrual period? No Yes
- 5: Did your migraine headaches interfere with your normal activities No Yes
- 6: Did you lose time from work due to your migraine headache? No Yes
If "yes" how many days? _____
- 7: Where are your migraine headaches located (check all that apply)
- | | | |
|--|---|---|
| <input type="checkbox"/> Behind right eye | <input type="checkbox"/> Behind left eye | <input type="checkbox"/> Behind both eyes |
| <input type="checkbox"/> Right temple | <input type="checkbox"/> Left temple | <input type="checkbox"/> Both temples |
| <input type="checkbox"/> Above right eyebrow | <input type="checkbox"/> Above left eyebrow | <input type="checkbox"/> Above both eyebrows |
| <input type="checkbox"/> Back of head right side | <input type="checkbox"/> Back of head left side | <input type="checkbox"/> Back of head on both sides |

8: Do any of the following occur before or during your migraine headaches?; (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bothered by light/noise | <input type="checkbox"/> Blurred/double vision | <input type="checkbox"/> Sparkling, flashing, lights |
| <input type="checkbox"/> Eyelid puffy | <input type="checkbox"/> Eyelid droops | <input type="checkbox"/> Loss of vision |
| <input type="checkbox"/> Feeling light headed | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Weakness of arm or leg |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Speech difficulty | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Other _____ | |

9: Did you take and *prescription* drugs to treat you migraine headaches? No Yes

*If "yes" list the medications _____

*How many time have you taken the medication in the last month? _____

10: 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 taken the medicine? _____

11: Did you need any other treatment, besides the medication, to relieve your migraine?

12: How would you rate your general health?

Excellent good Fair Poor

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

Extremely Moderately Very little Not at all