Mid Maryland Neurology

Initial Visit Headache Questionnaire

Name: _____ **Date:** _____

Onset:

At what age did you start having headaches? _____

Frequency:

How many total days a month do you have some form of headache? (all headaches) _____

How many days in the past month did you take pain medicine? _____(***including*** OTCs Excedrin, Tylenol, etc.)

How often do your headaches occur?

_____ X /Day _____ X /Week _____ X /Month _____ X /Year ❑ Constant

How long ago did the *current* headache start? (if constant) _____

Has your headache pattern changed in the last three to six months? How?

_____

Duration:

How long does a typical headache last?

_____ Seconds _____ Minutes _____ Hours _____ Days ❑ Constant

Quality of Pain

How would you best describe the quality of the pain? *Check all that apply*

Throbbing/pulsating	Pressing/squeezing	Stabbing	Dull/nagging	Other
❑	❑	❑	❑	❑

Does the headache ever waken you from sleep? ❑ Yes ❑ No

Location:

On what part of your head does the headache start?

❑ Left	❑ Right	❑ Both sides	❑ Around eye	❑ All over
❑ Front	❑ Back			

Severity:

Mark down the number of headaches each month that are:

Mild _____ Moderate _____ Severe _____

How would you grade the severity of your *average* headache?

❑ 1(least) ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑10(worst)

Associated Symptoms:

- ❑ Nausea
- ❑ Vomiting
- ❑ Light sensitivity
- ❑ Noise sensitivity
- ❑ Loss of vision
- ❑ Flashing lights
- ❑ Visual blurring
- ❑ Double vision
- ❑ Tearing
- ❑ Nasal congestion
- ❑ Drooping eyelid
- ❑ Strange visual patterns (zigzags, sparkling, shimmering or colored lights)
- ❑ Difficulty speaking
- ❑ Difficulty understanding
- ❑ Numbness
- ❑ Weakness
- ❑ Dizziness/vertigo

❑ Do you ever have ***warning symptoms*** 20 to 30 minutes prior to a headache? ❑ Yes ❑ No

❑ Other?

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Triggers:

Check any of the following that seem to bring on your headaches.

❑ Menstrual cycle	❑ Missed meals	❑ Other:
❑ Insufficient sleep	❑ Odors	
❑ Change in weather	❑ Stress	
❑ Loud noises	❑ Bright lights	
❑ Exertion	❑ Alcohol	
❑ Sex	❑ Motion Sickness	
❑ Foods: (list)		

Treatment:

Have you tried the following ***abortive*** headache medications. *Check **if used***

Medication	*Effective?*	*Side effects (if any)*
❑ Sumatriptan (Imitrex)	❑ Yes ❑ No	
❑ Sumatriptan and Naproxyn (Treximet)	❑ Yes ❑ No	
❑ Rizatriptan (Maxalt)	❑ Yes ❑ No	
❑ Almotriptan (Axert)	❑ Yes ❑ No	
❑ Eletriptan (Relpax)	❑ Yes ❑ No	
❑ Zolmatriptan (Zomig)	❑ Yes ❑ No	
❑ Naratriptan (Amerge)	❑ Yes ❑ No	
❑ Frovatriptan (Frova)	❑ Yes ❑ No	
❑ Dihydroergotamine (Migranal or DHE)	❑ Yes ❑ No	
❑ Prednisone	❑ Yes ❑ No	
❑ Isometheptene/dichloralphenazone (Midrin)	❑ Yes ❑ No	
❑ Ketorolac: Toradol, Sprix	❑ Yes ❑ No	
❑ NSAIDs: ibupofen/naproxyn/diclofenac	❑ Yes ❑ No	
❑ Others:		

Have you tried the following ***preventative*** headache medications. *Check **if used***

Medication	*Effective?*	*Side effects (if any)*
❑ Amitriptyline, nortriptyline(Elavil,Pamelor)	❑ Yes ❑ No	
❑ Propranolol, metoprolol, atenolol	❑ Yes ❑ No	
❑ Depakote	❑ Yes ❑ No	
❑ Topiramate(Topamax,Trokendi, Qudexy)	❑ Yes ❑ No	
❑ Verapamil	❑ Yes ❑ No	
❑ Zonisamide	❑ Yes ❑ No	
❑ Botox	❑ Yes ❑ No	
❑ CGRP mAb's:Aimovig, Ajovy Emgality	❑ Yes ❑ No	

Tests:

Check all tests you have had for your headaches

Test	*Date*	*Results*
❑ MRI head		
❑ MRI C-spine		
❑ CT head		
❑ EEG		
❑ Spinal tap		
❑ Blood work		

The Migraine Disability Assessment Test

The **MIDAS** (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS

Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your healthcare professional.

_____ 1. On how many days in the last 3 months did you miss work or school because of your headaches?

_____ 2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

_____ 3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

_____ 4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

_____ 5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

_____ Total (Questions 1-5)

What your Physician will need to know about your headache:

_____ A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.)

_____ B. On a scale of 0 - 10, on average how painful were these headaches? (where 0=no pain at all, and 10= pain as bad as it can be.)

Scoring: After you have filled out this questionnaire, add the total number of days from questions 1-5 (ignore A and B).

MIDAS Grade	Definition	MIDAS Score
I	Little or No Disability	0-5
II	Mild Disability	6-10
III	Moderate Disability	11-20
IV	Severe Disability	21+

If Your MIDAS Score is 6 or more, please discuss this with your doctor.