HEADACHES (INCLUDING MIGRAINE HEADACHES)
DISABILITY BENEFITS QUESTIONNAIRE

Name of Claimant/Veteran:	Claimant/Veteran's Social Security Number:	Date of Examination:
[redacted]	[redacted]	[redacted]

Note to examiner – The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

Is this questionnaire being completed in conjunction with a VA C&P examination request?

☒ Yes ☐ No

How was the examination completed? (check all that apply)

☒ In-person examination

☒ Records reviewed

☐ Examination via approved video telehealth

☐ Other, please specify in comments box

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

Indicate the method used to obtain medical information to complete this document:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or video telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

Evidence reviewed (check all that apply):

☐ Not requested

☐ VA claims file (hard copy paper C-file)

☒ VA e-folder

☐ No records were reviewed

☐ VA electronic health record

☐ Other, please specify in comments box

Evidence comments:

SECTION I - DIAGNOSIS

Note: These are condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. List the claimed condition(s) that pertain to this questionnaire:

Migraines

Note: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition(s), explain your findings and reasons in the Remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis or an approximate date determined through record review or reported history.

1B. Select diagnoses associated with the claimed condition(s) (check all that apply):	ICD Code:	Date of diagnosis:
☐ The Veteran does not have a current diagnosis associated with any claimed condition(s) listed above. Explain your findings and reasons in the Remarks section)		
☒ Migraine including migraine variants	G43.909	06/2022
☐ Tension		
☐ Cluster		
☐ Other (specify type of headache):		
Other diagnosis #1:		
Other diagnosis #2:		

	Other diagnosis #3:		

1C. If there are additional diagnoses that pertain to a headache condition, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history, including onset and course, of the Veteran's headache condition(s). Brief summary:

Migraine including migraine variants
Date of onset:
2018
Details of onset:
Service member reports during deployment to Afghanistan, he started to experience migraine headaches, which have continued.
Course since onset:
Migraines occur 2-3 times per week typically lasting 1-6 hours, and occasionally lasting the entire day. Previous treatment includes Fioricet. He was recently switched to Sumatriptan PRN.

2B. Does the Veteran's treatment plan include taking daily prescribed medication for the diagnosed condition(s)?

☐ Yes ☒ No

If yes, list only those medications used for the diagnosed condition(s):

SECTION III - SYMPTOMS

3A. Does the Veteran experience headache pain?

☒ Yes ☐ No

(If "Yes", check all that apply to headache pain):

☒ Constant head pain
☒ Pulsating or throbbing head pain
☐ Pain localized to one side of the head
☒ Pain on both sides of the head
☒ Pain worsens with physical activity
☐ Other, describe:

3B. Does the Veteran experience non-headache symptoms associated with headaches? (Including symptoms associated with an aura prior to headache pain)

☒ Yes ☐ No

(If "Yes," check all that apply):

☐ Nausea
☐ Vomiting
☒ Sensitivity to light
☒ Sensitivity to sound
☐ Changes in vision (such as scotoma, flashes of light, tunnel vision)
☐ Sensory changes (such as feeling of pins and needles in extremities)
☐ Other, describe:

3C. Indicate duration of typical head pain

☒ Less than 1 day
☐ 1-2 days
☐ More than 2 days

☐ Other, describe:

3D. Indicate location of typical head pain

☐ Right side of head

☐ Left side of head

☒ Both sides of head

☐ Other, describe:

SECTION IV – PROSTRATING ATTACKS OF HEADACHE PAIN

Note: For VA purposes, the term prostrating means "causing extreme exhaustion, powerlessness, debilitation or incapacitation with substantial inability to engage in ordinary activities." Please complete both questions 4A and 4B.

4A. Migraine / non-migraine – Does the Veteran have characteristic prostrating attacks of migraine / non-migraine pain?

☒ Yes ☐ No

(If "Yes," indicate frequency on average, of prostrating attacks over the last several months):

☐ With less frequent attacks
☐ Once in 2 months
☐ Once every month
☒ Greater than once per month

4B. Does the Veteran have completely prostrating and prolonged attacks of migraines / non-migraine pain?

☒ Yes ☐ No

(If "Yes," indicate frequency on average, of completely prostrating attacks over the last several months):

☐ With less frequent attacks
☐ Once in 2 months
☐ Once every month
☒ Greater than once per month

SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

5A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the diagnosis section above?

☐ Yes ☒ No

If yes, describe (brief summary):

5B. Does the Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis section?

☐ Yes ☒ No

If yes, also complete the appropriate dermatological questionnaire.

5C. Comments, if any:

SECTION VI - DIAGNOSTIC TESTING

NOTE: Diagnostic testing is not required for this examination report; if studies have already been completed, provide the most recent results below.

6A. Are there any other significant diagnostic test findings and/or results?

☐ Yes ☒ No

If yes, provide type of test or procedure, date and results (brief summary):

SECTION VII - FUNCTIONAL IMPACT

Note: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

7A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?

☒ Yes ☐ No

If yes, describe the functional impact of each condition, providing one or more examples:

Current OR if Retired/Unemployed, Previous Occupation:
Current: Military

1-2 weeks work time lost in last 12 months

Service member reports migraine head pain results in difficulty completing occupational tasks.

SECTION VIII - REMARKS

8A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

Is there a need for the Veteran/Service Member to follow up with his or her primary care provider regarding any life threatening or abnormal findings in this examination (not limited to claimed condition(s))? No

Is the Veteran homeless? No
Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION IX- EXAMINER'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

9A. Examiner's signature:	9B. Examiner's printed name:	9C. Date signed:
[redacted] Digitally Signed 02/28/2025 01:04:00 PM PA-C	[redacted] Physician Assistant – General Practice	2/28/2025
9D. Examiner's phone/fax numbers:	**9E. National Provider Identifier (NPI) number:**	**9F. Medical license number and state:**
[redacted]	1508508284	PA15701, TX

9G. Examiner's address:

540 Oak Centre Drive Suite 101 San Antonio TX 78258