Lions Gate Neurosciences

Headache Pre-Visit Questionnaire

Name: _____

Date of Birth: _____ Race: _____

Phone: _____ Cell Phone: _____

Email: _____

Best contact method: _____ Preferred Pronouns: _____

Family Doctor & Specialists: _____

Preferred Pharmacy (Name + Location): _____

Height: _____ Weight: _____

Current/Previous Job: _____ Are you left or right-handed? _____

Do you drive? _____ Do you live alone or with others?_____

Reason for Referral/Chief Complaint: _____

Past Medical History/Chronic Health Conditions: Place a ✓ in the column(s) that apply.

	Yes	No		Yes	No
High Blood Pressure			Thyroid Disease		
High Cholesterol			Asthma		
Diabetes			Migraine Headaches		
Stroke			Cancer		
Heart Disease			Other (specify below)		

Other: _____

Past Surgeries: _____

Allergies: _____

Review of Recent Symptoms: Place a ✓ in the box(es) that apply.

☐ Unexpected Weight Loss ☐ Night Sweats ☐ Fainting/Lightheadedness

☐ Dry Eyes and Dry Mouth ☐ Constipation ☐ Chest Pain

☐ Shortness of Breath ☐ Palpitations ☐ Early Satiety/Loss of Appetite

☐ New Skin Rashes ☐ Incontinence ☐ Other: _____

☐ Other (continued): _____

Current Medications:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

What disease(s), if any, are present in your family members, particularly **ages less than 65**:

_____

Neurologic disease(s):

_____

Have you ever smoked cigarettes? _____ If so, from what ages? _____ How much? _____

How many alcoholic drinks do you have per week? _____

Do you use any other substances? _____

How many types of headaches do you have, please describe: _____

_____

Migraine headache age of onset: _____

How many headaches days per month: _____

Associated headache symptoms? e.g., sensitivity to light, sound, movement, nausea, vomiting, ear ringing, neck pain, jaw pain, dizziness

_____

Headache characteristics: e.g., sharp, dull, left sided?

_____

How long do your worst headaches last? _____

Are you aware of your headache triggers: e.g. alcohol, cheese, coffee, weather, medications, menstrual cycle, TMJ, neck pain, irregular meals, poor sleep, etc.

_____

Do your headaches have any of these associated features: excessive tearing, droopy eyelid, abnormal pupils, nasal stuffiness, eyelid swelling, red eyes, abnormal facial sweating, neck pain, jaw pain

_____

Any risk factors for headaches: e.g., stress, sleep, sleep apnea, brain trauma, strokes, seizures, brain masses, family history of migraines

_____

_____

Do you use a headache diary? _____

How has it changed or affected your life: _____

_____

Any prior mood disorders: _____

Sleep issues, falling vs staying asleep: _____

Any history of brain imaging? What kind and when? _____

Medications used to treat individual ongoing headaches at onset:_____

_____

Medications used to prevent headaches (please list all, including dates taken):_____

_____

If you believe you have MIGRAINE headaches, please fill out the MIDAS form on the next page.

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.