Maia U. Chakerian, MD
Silicon Valley Pain Center

MIGRAINE/HEADACHE QUESTIONNAIRE

PLEASE PRINT

Name: _____ Date: _____

1) **AGE:** How old were you when you had your first migraine headache?_____
   a) For Females: Was it with onset of menstruation (period)?_____
   b) Was there any specific event that occurred that you could relate to the onset of migraines, or did it come on gradually?

   _____

   _____

2) **PAST HISTORY**:
   a) Does anyone else in your family (i.e. mother, father, grandparents, or other family members) have migraine headaches?

   _____

   b) Have you ever been formally evaluated for your headaches? _____
      i) If yes, By whom and when? _____
      ii) Was the doctor a neurologist?_____. If not, indicate what type of specialist diagnosed your migraine._____
      iii) Did you ever have a CT scan or MRI scan of your head? _____
      ---If yes, what were the results?

      _____

      _____

   c) Over the past 5 years, have your headaches worsened? Stayed the same? Improved?

   _____

   d) Do you get chronic daily headaches or tension headaches in addition to migraines? _____. If yes, please describe.

   _____

   _____

   _____

3) **FREQUENCY**: How many times per month do you get a migraine headache?

   _____

4) **DURATION**: How long does your headache last (in days)? _____

5) **SEVERITY**: On a scale of 1-10 (with 10 being the worst), how would you rate your headache pain? _____

14601 S. Bascom Ave. Ste. 240
Los Gatos,Ca 95032
Telephone. 408-356-0503
www.svpaindoc.com

6) **DISTRIBUTION**: Please describe specifically where on your body you typically get the headache pain? For example: Is the pain on one side or both sides of your head? Where does it usually start? Does it shift from side-to-side? Is it found behind your eyes? Does the pain distribution also include your neck?

_____
_____
_____
_____

7) Please describe any other specific or unusual details that might characterize your headache.

_____
_____
_____
_____

8) **AURA**: Definition: An aura is a "feeling of disconnection" **prior to** an actual migraine headache. Do you typically experience an aura before your migraine headaches?____
If yes, please describe:

_____
_____
_____

9) **ASSOCIATED SYMPTOMS**: Please indicate whether you experience the following Symptoms when you get migraine headache pain (yes or no):

a) Nausea? _____
b) Vomiting? _____
c) Photophobia (sensitivity to light)? _____
d) Phonophobia (sensitivity to sound)? _____
e) Please describe any other associated symptom(s) that you may experience during a migraine headache:

_____
_____
_____
_____
_____

14601 S. Bascom Ave. Ste. 240
Los Gatos,Ca 95032
Telephone. 408-356-0503
www.svpaindoc.com

10) <u>MEDICATIONS AND TREATMENTS</u>:

a) Please list all current medications that you take for migraine headaches. Also list any side effects you may be experiencing from use of this medication(s).

_____
_____
_____
_____
_____

b) Please list all medications that you have taken in the past that for any reason you are now unable to take, or which were not effective. Please list any side effects you may have experienced.

_____
_____
_____
_____

c) Do you currently take the drug IMITREX or similar type drug?_____. If so, does it relieve your headache? _____. How long does this drug provide relief (in hours)?_____. How long have you been taking Imitrex (or any similar drug)?_____. Do you find Imitrex (or similar drug) to be: a) more effective; b) less effective; or c) just as effective now as when you first began taking the medicine? _____. What side effect do you experience with Imitrex or similar type drug?

_____
_____
_____
_____

d) Other than medication, are there any other treatments (i.e. acupuncture or homeopathic remedies) that you use to help relieve your migraine headache pain? (Yes or No) _____. If yes, please describe:

_____
_____
_____

f) What do you do if medications do not relieve your headache?

_____
_____
_____
_____

14601 S. Bascom Ave. Ste. 240
Los Gatos,Ca 95032
Telephone. 408-356-0503
www.svpaindoc.com

Maia U. Chakerian, MD
Board Certified Specialist in Pain Medicine

11) JOB/ LIFESTYLE:

a) If currently employed, approximately how much time (hour/month on average) do you miss from work?

b) How do migraine headaches affect planning for your daily activities?

c) How do migraine headaches affect your overall life?

12) OTHER MEDICAL HISTORY:

a) Do you have any other medical problems?

(Please list)

13) PLEASE LIST ALL MEDICATIONS TAKEN:

Name of Medication	Dose	Frequency	Date started	Prescriber

14) ALLERGIES:

15) PAST SURGERIES AND DATES:

14601 S. Bascom Ave. Ste. 240
Los Gatos,Ca 95032
Telephone. 408-356-0503
www.svpaindoc.com