



Dean

HEALTH SYSTEM

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Headache Follow-Up Visit (Patient)

Date of Last Office Visit
(____ / ____ / ____)

Last Menstrual Period _____

Could you be pregnant? yes no

Using Contraception? yes no



Migraine Disability Assessment Survey

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you.

How do your headaches affect your day to day living _____

Instructions:

Please answer the following questions about all your headaches over the last **3 months**. Write your answer on the line next to each question. Write zero if you did not do the activity in the last **3 months**.

1. On how many days in the last 3 months did you miss work or school because of your headaches? (If you did not attend work or school enter zero in the box.) _____
DAYS

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. If you do not attend work or school, enter zero.) _____
DAYS

3. On how many days in the last 3 months did you not do household work because of your headaches? _____
DAYS

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

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

Questions 1-5	TOTAL

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

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

PLEASE COMPLETE QUESTIONS ON REVERSE SIDE

Since your last office visit:

of Emergency Room/Urgent Care visits for headache treatment since last seen? _____

Headache Frequency (<i>please circle</i>):	Same	More Frequent	Less Frequent
Headache Severity (<i>please circle</i>):	Same	More Severe	Less Severe

Has there been any significant change in the character or quality of your headaches since last seen?

Yes No

What is the average time from start of your headache to its peak intensity?

(Minutes/Hours): _____

Sleeping Pattern: Good Fair Poor How many restful nights of sleep do you get? _____/week

Have you used over the counter (OTC) medications in the past 2 weeks? Yes No

If yes, what is the average number of days/week that OTC medications are used? _____

Which OTC medications? _____

Base your answer on your experience of **the last 4 weeks**:

Can you quickly return to normal activities after taking your migraine medication? Yes No

Can you usually count on your migraine medication to relieve pain **within 2 hours**? Yes No

Does **one dose** of medication usually relieve your headache and keep it away for **at least 24 hours**? .. Yes No

Is your migraine medication well tolerated? Yes No

Are you comfortable enough with your medication to plan your daily activities? Yes No

(Used with permission from Richard Lipton, MD)

How do you treat a moderate to severe headache? (What do you take/do?) _____

Women: Do you understand that you need to inform me if you become pregnant or begin breastfeeding?

Yes No

How satisfied are you with your current headache treatment? Not at all Somewhat Very

Would you like more information on a particular headache related topic? _____

Other Questions _____
