



Dr. Michael Stein
1844 San Miguel Drive, suite 316
Walnut Creek, CA 94596
(925) 938-5252

Date	Age	Sex	Name
------	-----	-----	------

This headache questionnaire is designed to help you and the doctor obtain an accurate description of your headache. Complete, concise information enables the physician to diagnose your particular type of headache and suggest the most appropriate methods to manage it. PLEASE TAKE THE TIME TO ANSWER THIS AS COMPLETELY AS POSSIBLE. You may make notes when necessary.

1. At what age did your first headache occur? _____

2. Describe the severity of your headache pain on a scale of 0 through 3.

- #3: Severe: A severe headache; normal activity has to be discontinued.
- #2: Moderate: A moderate headache, disturbing but not prohibiting normal activity; bed rest is not necessary.
- #1: Mild: A mild headache, allowing normal activity.
- #0: No headache

3. How frequently do you usually get a headache of each type?

- | | | | | | | |
|-----|-------|--------|------------|---------|-------|-------|
| #3: | DAILY | WEEKLY | BI-MONTHLY | MONTHLY | _____ | OTHER |
| #2: | DAILY | WEEKLY | BI-MONTHLY | MONTHLY | _____ | OTHER |
| #1: | DAILY | WEEKLY | BI-MONTHLY | MONTHLY | _____ | OTHER |

4. How long does each headache episode last?

- minutes less than 4 hours more than 4 hours days

Do they occur at regular intervals? Yes No

5. In which area of the head does most of your pain occur?

- | | |
|----------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Lower head and neck | <input type="checkbox"/> Nose and Jaw |
| <input type="checkbox"/> Top of head | <input type="checkbox"/> Front forehead |
| <input type="checkbox"/> Headband effect | <input type="checkbox"/> Temples, left / right (circle one) |

6. Check which symptoms that you get just before or during your headache.

- | | | |
|-----------------------------------------|-------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Speech problems | <input type="checkbox"/> Flushed face |
| <input type="checkbox"/> Eyes watering | <input type="checkbox"/> Sensitivity to lights | <input type="checkbox"/> Sensitivity to noises |
| <input type="checkbox"/> Ears ring | <input type="checkbox"/> Weakness/paralysis | <input type="checkbox"/> Runny nose |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Other |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Bright lights or spots | _____ |

7. Are you aware of contributing factors to your headache?

- | | | | |
|------------------------------------------|---------------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Lack of sleep | <input type="checkbox"/> Exercise | <input type="checkbox"/> Chewing | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Menstrual cycle | <input type="checkbox"/> Altitude | <input type="checkbox"/> Reading | <input type="checkbox"/> Hunger |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Strobe light | <input type="checkbox"/> Driving | <input type="checkbox"/> Food |
| <input type="checkbox"/> Perfume | <input type="checkbox"/> Sex | <input type="checkbox"/> Stress | <input type="checkbox"/> Other _____ |

8. Are you aware of factors that relieve your headache?

- | | | |
|------------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Lying still | <input type="checkbox"/> Cold cloth |
| <input type="checkbox"/> Breathing steam | <input type="checkbox"/> Dark room | <input type="checkbox"/> Other |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Walking | _____ |

9. Which other blood relatives have recurrent headaches?

- Mother Father Sister Brother Grandparents

- 10.
- | | | |
|----------------------------------------------------------|------------------------------|-----------------------------|
| Would you rate your overall health as good to excellent? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you eat nutritious foods at regular intervals daily? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you on a regular exercise program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you a regular user of alcohol, wine, beer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a history of drug or alcohol abuse? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do your headaches go away after sleeping? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you smoke? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a regular menstrual cycle? (females only) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you currently seeing a therapist for stress? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you received a blow or injury to your head? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If YES, please explain _____

11. What was the date of your last eye exam? _____

12. What was the date of your last dental exam? _____

13. What medications are you currently taking? _____

14. What headache medications have you previously taken? _____

15. On a scale of 1 through 3, how would you rate the amount of stress in your life?

- #1: Mild: Light pressure and occasionally stressful.
- #2: Moderate: Very stressful and frequently difficult to cope.
- #3: Severe: Extremely stressful and very difficult to cope.

16. Are you aware of previous tests or x-rays regarding your headaches?

- | | |
|----------|-----------------------|
| EEG | Skull X-Ray |
| CAT Scan | Blood Chemistry Panel |
| MRI | Other _____ |

NOTES:



Dr. Michael Stein
1844 San Miguel Drive, suite 316
Walnut Creek, CA 94596
(925) 938-5252

Migraine Questionnaire

INSTRUCTIONS: Please answer the following questions about ALL your headaches you have had over the last 3 months. Write your answer in the box 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?	
2. On 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 because of your headaches?	
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 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 headache?	
TOTAL	

- 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 = as bad as it can be)

Once you have filled in the questionnaire, add up the total number of days from questions 1-5 (Ignore A and B)

Grading system for the Midas Questionnaire:

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