Migraine Surgery Intake Questionnaire

Name: Date:

Telephone (Home): Telephone (Work):

Date of Birth: ☐Female ☐Male

Health Insurance Company:

PCP: Neurologist:

Before we get started evaluating your pain, we would like to inquire about your preferences in terms of the goals and types of care you feel you would respond best. Recommendations can be made with and without these considerations. Ultimately, you will need to make the right decisions with your provider. This questionnaire is lengthy, comprehensive and may require a few days since some questions involve trying and reporting on different maneuvers performed during your headaches.

1. How important is avoiding any long-term dependence on oral medications?
    a. I never want to have to always take medications.
    b. I would rather not take medications long-term, if at all possible.
    c. I would take long-term medication if it is strongly recommended.
    d. I would prefer to always manage my pain with oral medications rather than other forms of treatment.
2. How important is avoiding long-term injection (Botox) therapy (usually 31 injections every 3 months)?
    a. I never want to have to even see a needle..
    b. I would rather not need long-term injections, if at all possible.
    c. I am fine with long-term injection therapy.
    d. I would prefer to always manage my pain with injection therapy rather than other forms of treatment
3. How important is avoiding any outpatient surgeries?
    a. I cannot even consider outpatient surgery to eliminate or reduce my headache pain.
    b. I would like to avoid any surgery if at all possible.
    c. I would consider surgery if it was strongly recommended.
    d. I would prefer to have a sequential approach with smaller minimally invasive surgery/surgeries to address each zone as it becomes apparent. (This minimizes the risk of unnecessary surgery.)
    e. I would prefer to have a comprehensive approach that addresses any suspicious areas with one larger minimally invasive surgery. (This minimizes the likelihood for more than one surgery, but may add unnecessary surgery.)

4. How important is avoiding any lifestyle changes?
    a. I am unable to make any changes in my activity level.
    b. I am unable to make any changes in my work life.
    c. I am willing to speak with a pain psychologist and or physical therapist to determine if any of my activities/behaviors are contributing to my condition.
5. How important is avoiding any dietary changes?
    a. I do not want to consider any changes in modifying how I eat.
    b. I would place a premium on being able to eat and drink what I like without worrying about a severe headache.
    c. I would consider making changes in my diet if it would significantly reduce my headaches.

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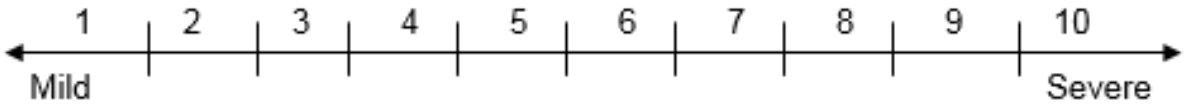
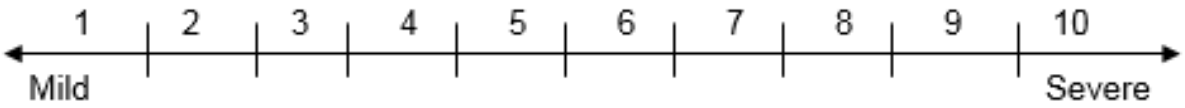
1. How many **migraine** headaches do you experience per month?_____
2. How many **regular** headaches do you experience per month? _____
3. How long do your migraine headaches usually last (in hours) ? _____

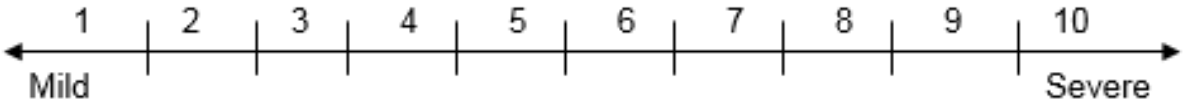
4. How painful are your headaches **<u>on average</u>**? (circle one number)



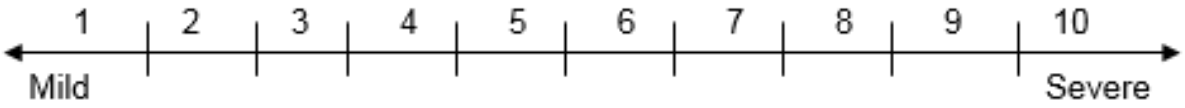
5. What is the **<u>worst</u>** headache that you experience regularly? (circle one number)



6. What is the **<u>mildest</u>** headache that you experience regularly? (circle one number)



7. What is your headache score **<u>today</u>**? (circle one number)



8. Does your headache score actually ever go to zero? ☐ YES ☐ NO

9. On which side of the head is your pain? ☐ right side ☐ left side ☐ both sides

10. Is your pain more prominent on the right side, the left side, or equal on both sides?
    ☐ right side ☐ left side ☐ both sides

11. Where do your migraine headaches usually **START**? (check all that apply)

☐ Behind right eye ☐ Behind left eye ☐ Behind both eyes

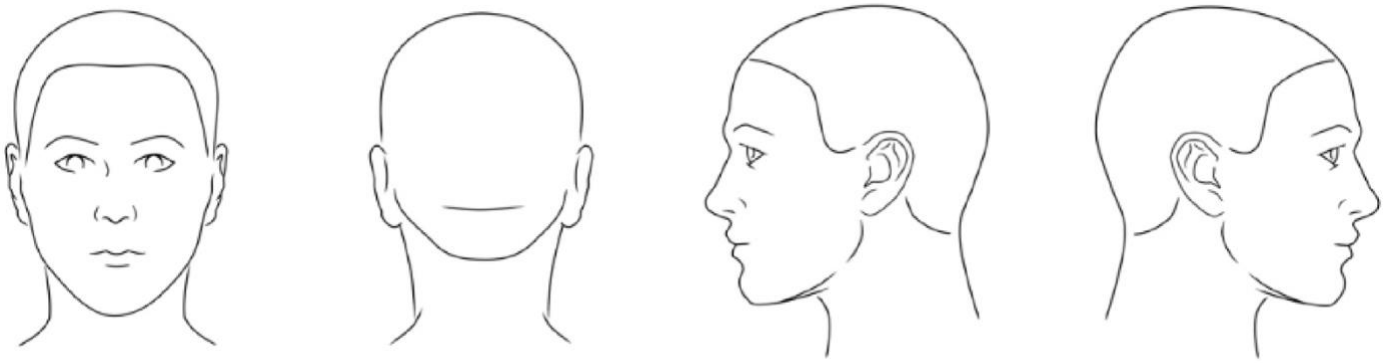
☐ Right temple ☐ Left temple ☐ Both temples

☐ Above right eyebrow ☐ Above left eyebrow ☐ Above both eyebrows

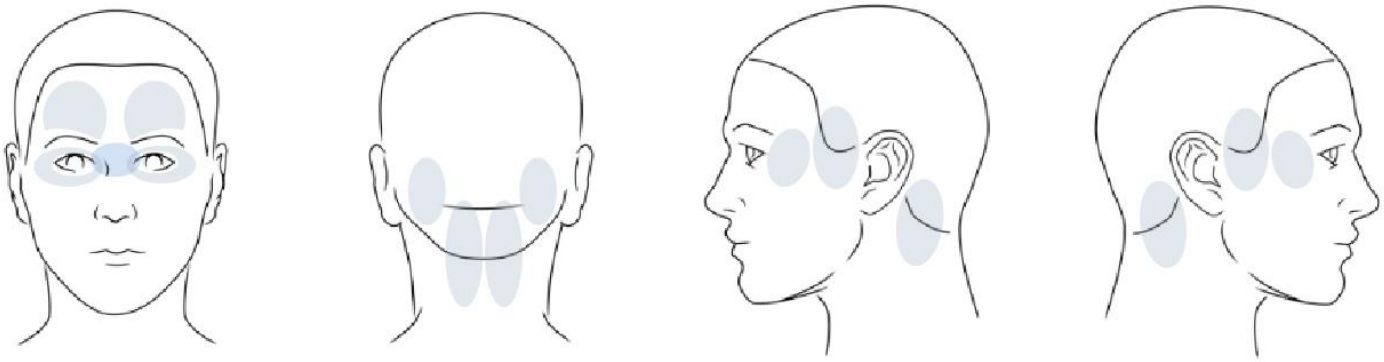
☐ Back of head on right ☐ Back of head on left ☐ Back of head on both sides

☐ Nose / center of face ☐ Other: Please describe _____

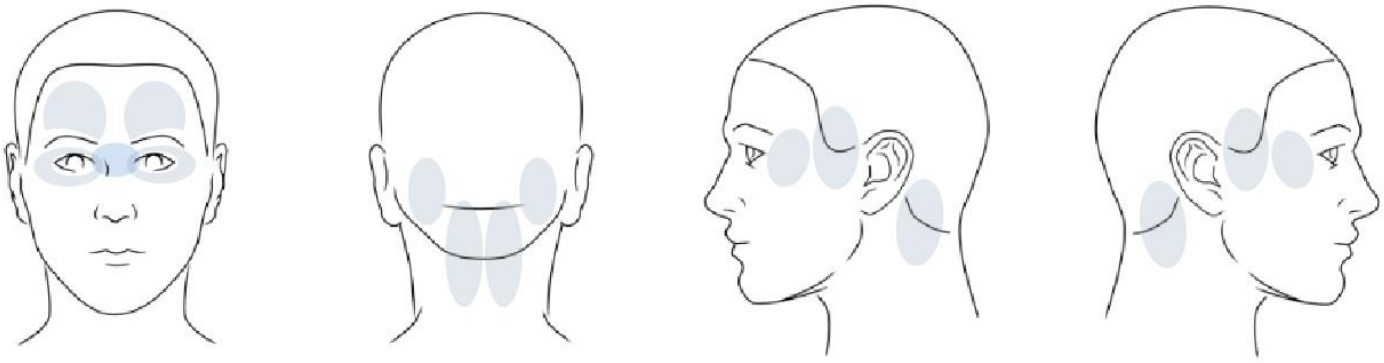
12. Please use the pictures to draw where the pain starts and where it spreads. Use X for where it starts or is more severe, and arrows for where it spreads.



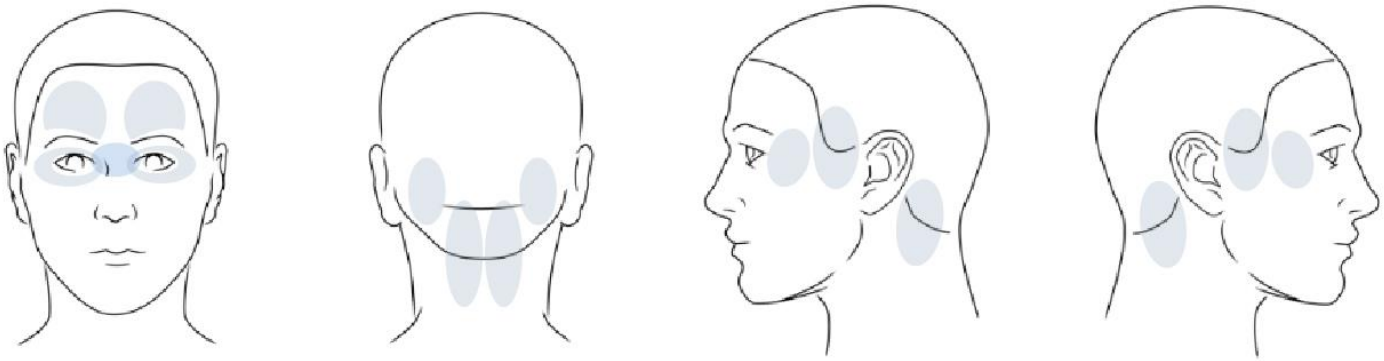
13. Please use the pictures, similarly, to number the sequence of pain with “1” indicating where the headache begins and the last number where your pain is last to arrive.



14. Please use the pictures to indicate the percentages of your worst headache pain in each area as a portion of your total pain (100%)

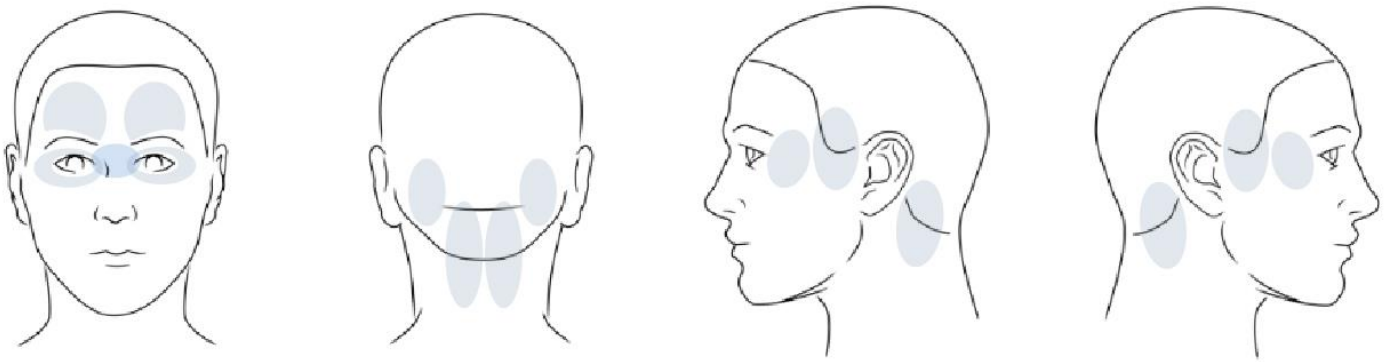


15. Please use the pictures to indicate any areas where you have tenderness to the touch/pressure and whether it is



a. Always
b. Often or always with headaches
c. Occasionally with headaches
d. Do not have tenderness

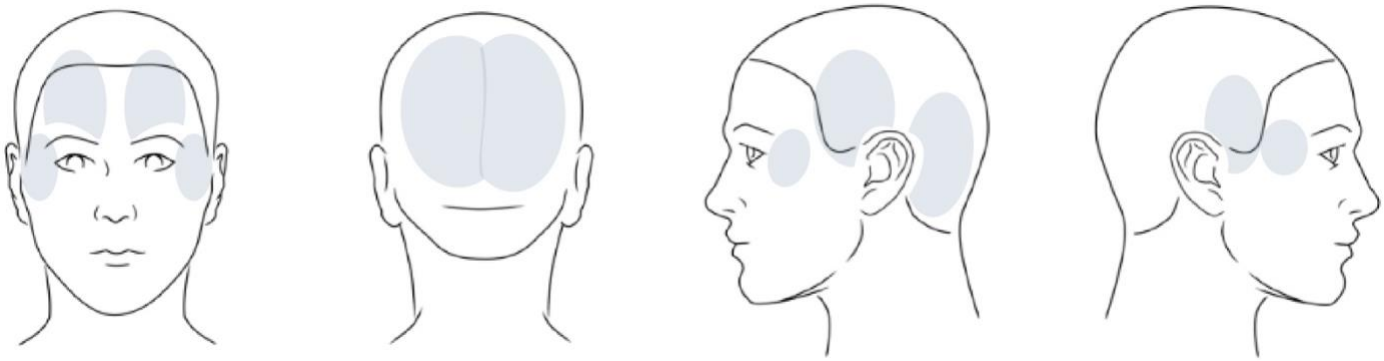
16. Please use the pictures to indicate any areas where you have “shocky” sensations when you briskly tap the indicated areas with a fingertip (this is something you probably have not tried before – No worries!)



and whether it is

a. Always
b. Often or always with headaches
c. Occasionally with headaches
d. Do not have “shocky” sensations anywhere with tapping.

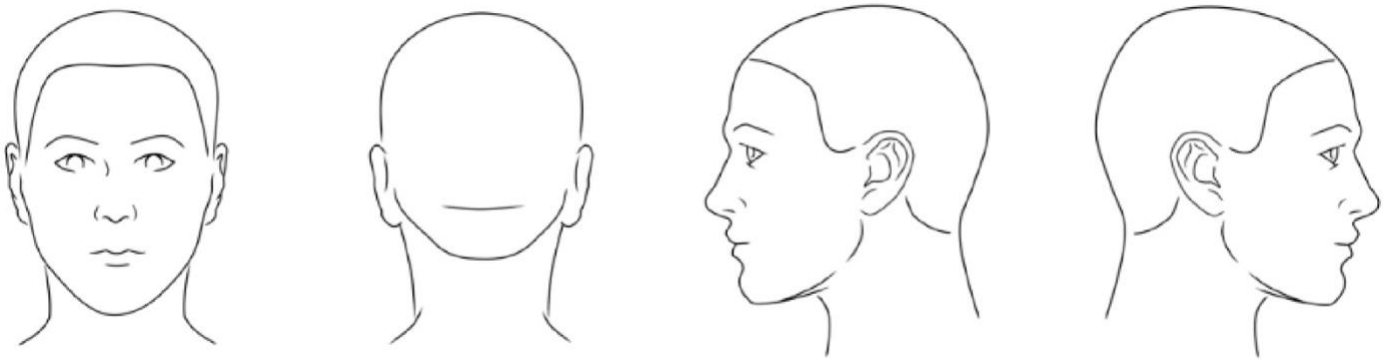
17. Please use the pictures to indicate any areas where your skin or scalp is painful or even just too sensitive to the touch (compare sides).



Indicate whether this is

a. Always
b. Often or always with headaches
c. Occasionally with headaches
d. Do not have areas of excessive or inappropriate sensation.

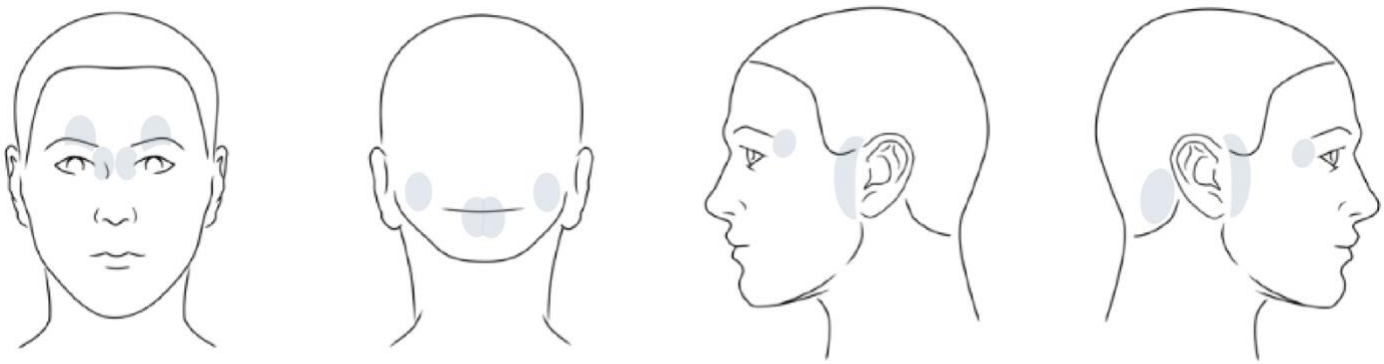
18. Please use the pictures to indicate any areas where you always **avoid touching**.



19. Please use the pictures to indicate any areas where firm pressure relieves some or all of your headache pain in a particular area. (Show Angular, SOA, STA, OA zones and Nummular/Scalp)
    a. Pressure always or usually relieves some or all of the pain in this area.
    b. Pressure sometimes relieves some or all of the pain in this area.
    c. Pressure rarely but occasionally will completely relieve the pain in this area.
    d. Pressure has no effect or causes pain (No areas indicated).

20. Does firm pressure in any of the following **combined** areas relieve any or all of your pain. (This may be something you have not tried before).

    i. 1&2 ii. 1&2&3 ii. 3&4



    b. Pressure always or usually relieves some or all of the pain in these areas.
    c. Pressure sometimes relieves some or all of the pain in these areas.
    d. Pressure rarely or occasionally will completely relieve the pain in these areas.
    e. Pressure has no effect or causes pain (No areas indicated).

21. Does the pain ever seem to be coming from everywhere or inside your head (you may circle more than one)?
    a. Yes, constantly as a background headache.
    b. Yes, much of the time when I have a background headache.
    c. Yes, with most of my migraine headaches.
    d. Only with my worst headaches.
    e. Almost never – my pain is in the areas I have indicated.
    f. Yes, particularly with my waking or morning headaches.

22. How old were you when your **migraine** headaches started? _____

23. Might your headaches have significantly worsened or started within a year following a trauma or surgery to the head, face neck or nose? ☐ YES ☐ NO
    a. If yes, describe
    _____
    _____
    _____

24. Was there any event that you believe caused/started your migraines?
    ☐ YES ☐ NO
    If yes, what event? _____

25. Have you ever had a **head or neck injury** (e.g. whiplash, facial fractures, concussion)? ☐ YES ☐ NO
    a. If yes, please describe: _____

26. Have you ever had a **broken nose or nasal or sinus surgery**? ☐ YES ☐ NO
    a. If yes, please describe: _____
    _____

27. Do you have difficulties breathing from either nostril? ☐ YES ☐ NO
    ☐ RIGHT ☐ LEFT

28. Do you or one of your physicians suspect that a health disorder is somehow related to your migraine headaches?

☐ YES ☐ NO

a. If yes, please describe: _____

_____

29. How would you describe the pain associated with your migraine headaches? (check all that apply)

☐ Throbbing or pounding

☐ Aching or pressure

☐ Tightness

☐ Dull pain

☐ Other: _____

30. Do your migraine headaches wake you up at night?

☐ Never

☐ Occasionally

☐ Often

31. Do any of the following occur before or during your migraine headaches? (check all that apply)

☐Nausea ☐Vomiting ☐Diarrhea

☐Bothered by light/noise ☐Blurred/double vision ☐Sparkling, flashing, or colored lights

☐Eyelid puffy ☐Eyelid drooping ☐Loss of vision

☐Lightheadedness ☐Numbness / tingling ☐Weakness of arm or leg

☐Difficulty concentrating ☐Speech difficulty ☐Loss of consciousness

☐Runny nose ☐Other:_____

32. Do you experience nausea with your headaches?

a. Always
b. Usually
c. Sometimes
d. Almost never
e. Never

33. Do you experience vomiting with your headaches?
    a. Always
    b. Usually
    c. Sometimes
    d. Almost never
    e. Never

34. How many times per month do you vomit with your headaches? _____

35. Do any of the following trigger your migraine headaches or make them worse? (check all that apply)

☐Stress (worry, anger)	☐Bright sunshine	☐Weather change
☐Letdown after stress	☐Loud noise	☐Heavy lifting
☐Air travel	☐Fatigue	☐Certain smells or perfume
☐Missed meals	☐Sexual activity	☐Coughing, straining, bending over
☐Certain foods (chocolate, cheese, beer, MSG)		☐Other: _____

36. Do any of the following make your migraine headaches better?

☐Rest	☐Exercise	☐Quiet and darkness
☐Hot or cold compress	☐Massage	☐Warm shower
☐Pressure over migraine headache area		☐Other: _____

37. If you are female, do your migraine headaches change with the following? (check all that apply)

    ☐Menstrual periods

    ☐Birth control pills

    ☐Pregnancy

    ☐Other hormonal drugs

    If yes, have the conditions mentioned above made your migraines better or worse?

    ☐ Better ☐ Worse

38. a. How many neurologists have you seen for your migraines? _____

Please list their names:

_____

_____

_____

b. What was the diagnosis? (check all that apply)

☐Migraine ☐Tension-Headache ☐Cluster ☐ Occipital Neuralgia ☐Trigeminal Neuralgia ☐ Chronic Migraine ☐ Episodic Migraine ☐Cervicogenic Headache

☐Other: _____

39. Have you had any of the following **radiology studies** performed?

a. MRI (Head): ☐ YES ☐ NO

i. If yes, date of study: _____

b. MRI (Neck): ☐ YES ☐ NO

i. If yes, date of study: _____

c. CT Scan (Head/Neck): ☐ YES ☐ NO

i. If yes, date of study: _____

d. Other ☐ YES ☐ NO

i. If yes, type and date of study: _____

If you answered yes to any of the radiology studies, please bring copy of reports to your appointment

40. Please list **current** medications you are taking to treat your migraine headaches:

a. Preventative (Prophylactic):

b. Rescue (Abortive):

41. Please check any **past medications** you have taken to treat your migraine headaches:

a. Anti-inflammatory:

☐ Aspirin ☐ Advil ☐ Toradol ☐ Tylenol

☐ Excedrin ☐ Aleve ☐ Cortisol ☐ Prednisone

☐ Dexamethasone ☐ Other: _____

b. Narcotics:

☐ Fiorinal ☐ Vicodin ☐ Percocet ☐ Demerol

☐ Oxycontin ☐ Oxycodone ☐ Hydrocodone ☐ Fioricet

☐ Other: _____

c. Abortive:

☐ Cafegot ☐ Relpax ☐ Treximet ☐ Maxalt

☐ Amerge ☐ Frova ☐ Zomig ☐ Midrin

☐ Sumatriptan ☐ Imitrex ☐ Other: _____

d. Preventative:

☐ Propranolol ☐ Timolol ☐ Nadolol ☐ Metoprolol

☐ Atenolol ☐ Verapamil ☐ Diltiazem ☐ Amitriptyline

☐ Nortriptyline ☐ Topiramate ☐ Elavil ☐ Topamax

☐ Clonidine ☐ Feverfew ☐ Dilantin ☐ Depakote

☐ Zoloft ☐ Paxil ☐ Prozac ☐ Effexor

☐ Wellbutrin ☐ Trazodone ☐ Protriptyline ☐ Desipramine

☐ Doxepin ☐ Other: _____

e. Miscellaneous:

☐ Phrenilin ☐ DHE ☐ Baclofen ☐ Gabapentin

☐ Cymbalta ☐ Other: _____

42. Please list any **over-the-counter (OTC)** medications related to migraine that you are currently taking:

_____

_____

_____

_____

43. Please list the two medications that have been most successful for the longest period of time.

_____

_____

44. Have you ever had **Botox** to treat your migraines? ☐ YES ☐ NO

    a. Where? ☐ Back of head (occipital region) ☐ Front of head (forehead/brow) ☐ Both

    b. Who performed your Botox injections? _____

    c. Did your Botox injections help?

☐ no relief (0%)

☐ some relief (<50%)

☐ significant relief (>50%, but not complete)

☐ complete relief (100%)

45. Have you ever had **nerve blocks** to treat your migraines? ☐ YES ☐ NO

    a. Where? ☐ Back of head (occipital region) ☐ Front of head (forehead/brow) ☐ Both

    b. Who performed your nerve blocks? _____

    c. Did your nerve blocks help at the time of the injection (while there was numbness)?

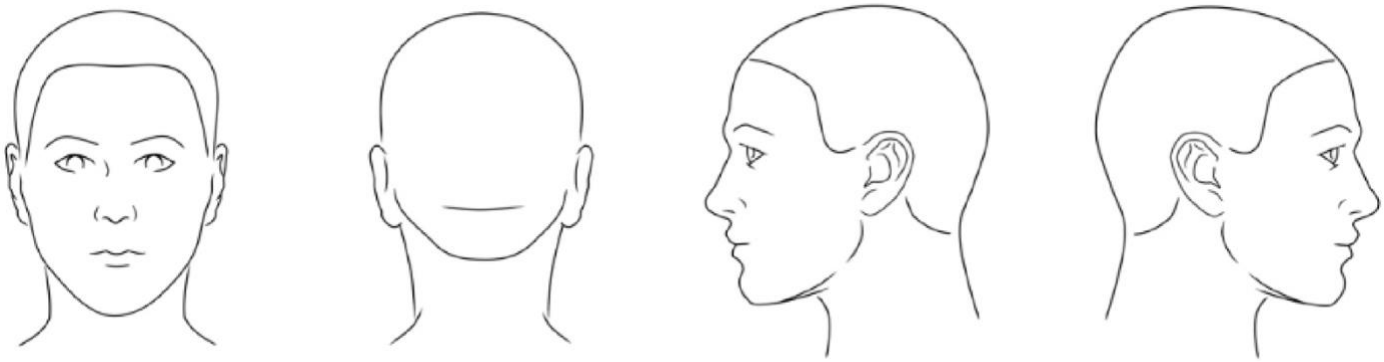
☐ no relief (0%)

☐ some relief (<50%)

☐ significant relief (>50%, but not complete)

☐ complete relief (100%)

46. Please use the pictures below to indicate the locations and approximate number of **steroid injections in each area.**



47. Have you ever had a **nerve stimulator** to treat your migraines? ☐ YES ☐ NO

    a. Where? ☐ Back of head (occipital region) ☐ Front of head (forehead/brow) ☐ Both

    b. Who performed your nerve stimulator?

    c. Which nerve stimulator was implanted?

    d. Did your nerve stimulator help?

☐ no relief (0%)

☐ some relief (<50%)

☐ significant relief (>50%, but not complete)

☐ complete relief (100%)

    e. For how many months did the nerve stimulator help?

48. Have you ever had **radiofrequency nerve ablation** to treat your migraines? YES NO

    a. Where? ☐ Back of head (occipital region) ☐ Front of head (forehead/brow) ☐ Both

    b. Who performed your nerve ablation? _____

    c. Did your nerve ablation help?

☐ no relief (0%)

☐ some relief (<50%)

☐ significant relief (>50%, but not complete)

☐ complete relief (100%)

    d. For how many months did the nerve ablation help?

49. Have you sought treatment in the emergency room or hospital for your migraine headaches?

☐No ☐Yes – If yes, how many times? _____

50. Please list any other treatment(s) you have received for your migraine headaches:

☐ acupuncture

☐ massage

☐ craniosacral therapy

☐ other: _____

51. How much would you estimate your migraine headache medications, appointments, and treatments cost you **per month**? _____

52. How many of these medical expenses would you estimate are covered by your health insurance **per month**? _____

53. To what extent do your migraine headaches affect your overall quality of life? (check one)

☐ Completely (unable to do desired activities)

☐ Moderately

☐ Minimally

☐ Not at all (able to do desired activities)

54. Do you have/had any of the following **<u>medical conditions</u>**? (check all that apply)

☐ Diabetes	☐ Heart attack	☐ Stroke
☐ Epilepsy	☐ Hypertension	☐ Hypotension
☐ Depression	☐ Fibromyalgia	☐ Thyroid disorder
☐ Asthma	☐ Lupus	☐ Peripheral neuropathy
☐ Carpal tunnel	☐ Shingles	☐ Cold sores/herpes

☐ Other: _____

55. Please list any previous surgeries you have had and when they took place:

_____

_____

_____

_____

_____

_____

_____

56. What is your approximate consumption of the following:

a. Coffee/Tea/Caffeinated Soda: _____ per day / week / month
b. Alcohol: _____ per day / week / month
c. Tobacco: _____ per day / week / month
d. Other intoxicating/mind altering drugs: _____ per day / week / month

57. Please list any **medication allergies** you have:

_____

_____

58. Do any of your family members have migraine headaches?

☐No ☐Yes – If yes, who? _____

59. Please list any additional information that you feel is important to your medical care/history:

_____

_____

_____

_____

_____

_____