

7. What is your educational background? (circle highest completed)

- a. 8 grades or less
- b. Some high school (did not graduate)
- c. High school graduate/GED
- d. Some college (post high school)
- e. Vocational-technical or associate (2 year) degree (A.A., etc.)
- f. College graduate (B.A., B.S., etc.)
- g. Some post-graduate work
- h. Masters level degree
- i. Doctoral level degree (Ph.D., M.D., etc.), or higher

8. Are you currently employed? Yes No

8a. If YES, please describe what you do in your job.

8b. If NO, please describe your last job and indicate when it ended.

9. What is the estimated total income per year of your household?

- | | |
|------------------------|------------------------|
| a. Under \$10,000 | b. \$10,000 - \$19,000 |
| c. \$20,000 - \$29,000 | d. \$30,000 - \$39,000 |
| e. \$40,000 - \$49,000 | f. \$50,000 - \$59,000 |
| g. \$60,000 - \$69,000 | h. \$70,000 or more |

10. Who referred you to the clinic? If not referred, how did you hear about this clinic? _____

11. Please provide us with the names, addresses and phone numbers of two people who will always know how to reach you (other than your spouse).

Name #1: _____

Address: _____

Phone(s): _____

Name #2: _____

Address: _____

Phone(s): _____

II. MEDICAL HISTORY

1. What was the approximate date of your last physical examination? _____

2. Are you currently under the care of a physician for your headaches? YES NO

2a. If YES, please list the name, address, and specialty of your doctor:

3. What was the approximate date of your last physician or emergency room visit for your headache problems? _____

4. Do you have a physician that you see when you are ill? YES NO

4a. If YES, please list the name, address, and specialty of your doctor:

4b. If NO, please list the name, address, and specialty of your previous doctor:

5a. About how many times have you seen a physician about your headaches in the past six (6) months? (include office visits, emergency room visits, etc.) _____

5b. About how many times have you seen a physician for reasons other than your headaches in the past six (6) months? (include office visits, emergency room visits, etc.) _____

6. Do you now, or have you ever had any of the following disorders?

	No	Yes	Age of Onset	List Family Members Also Diagnosed
Allergies	_____			
Angina (chest pain)	_____			
Arthritis	_____			
Asthma	_____			
Cancer	_____			
Chronic back or neck pain	_____			
Diabetes	_____			
Emotional/nervous disorder	_____			
Encephalitis	_____			
Epilepsy	_____			
Headache (migraine)				
Headache (tension)	_____			
Headache (other)				
Heart trouble				
Hepatitis				
High blood pressure				
Kidney disease	_____			
Liver disease	_____			
Mitral valve prolapse				
Stroke	_____			
Thyroid disorder	_____			
TMJ problems				
Ulcers	_____			
Other	_____			

14. Have you ever been under the care of a psychologist, psychiatrist, or other mental health professional? YES NO

If YES, please indicate:

- 14a. How long you were, or have you been, in treatment? _____
- 14b. When you were last treated? _____
- 14c. What you were treated for? _____
- 14d. What medications were prescribed? _____

15. What is your current height? _____ 15a. Current Weight? _____

16. What is the most you have weighed in the past 5 years? _____

17. What is the least you have weighed in the past 5 years? _____

18. In the past 6 months have you had any changes in your weight? YES NO

If YES:

- 18a. Did you: _____gain weight _____lose weight
- 18b. When did the changes occur? _____
- 18c. Why did the changes occur? _____

19. Have you experienced any recent changes in your sleep habits/patterns? YES NO

If YES:

- 19a. When did the changes occur? _____
- 19b. Describe the changes _____
- 19c. Why did the changes occur? _____

20. In a TYPICAL WEEK, how many days do you drink alcohol? 0 1 2 3 4 5 6 7 days

21. In a TYPICAL WEEK, how many days do you drink caffeinated beverages?
0 1 2 3 4 5 6 7 days

22. Have you ever smoked cigarettes regularly? YES NO

25. Do you currently smoke cigarettes? YES NO

If YES, please indicate:

- 25a. At what age did you begin smoking on a regular, daily basis? _____
- 25b. How many cigarettes do you smoke in a TYPICAL DAY? _____
- 25c. Are you interested in quitting smoking? YES NO

III. HEADACHE HISTORY

1. What level of headache are you experiencing right now? (Circle one)

0	1	2	3	4	5	6	7	8	9	10
No Headache	* Slightly Painful	* Mildly Painful	* Painful	* Very Painful	* Extremely Painful					

2. Check all headache diagnoses have you received from a physician.

- a. Migraine
- b. Muscle Contraction or Tension
- c. Sinus
- d. Mixed or Combined
- e. Cluster
- f. Vascular
- g. Posttraumatic
- h. Other, please specify _____

3. Which of the following procedures have ever been used by your physicians to arrive at your headache diagnosis? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> physical exam | <input type="checkbox"/> neurological exam |
| <input type="checkbox"/> EEG | <input type="checkbox"/> CT or CAT scan |
| <input type="checkbox"/> skull x-ray | <input type="checkbox"/> thermogram |
| <input type="checkbox"/> doppler flow study | <input type="checkbox"/> MRI or NMR tests |
| <input type="checkbox"/> blood tests | <input type="checkbox"/> lumbar puncture/spinal tap |
| <input type="checkbox"/> interview only | <input type="checkbox"/> cerebral angiogram/arteriogram |
| <input type="checkbox"/> Other (please describe): _____ | |
| <input type="checkbox"/> None | |

4. Which of the treatments below have you ever had for treatment of your headache(s)? (circle all that apply and use the following scale to estimate how often you experience adequate relief)

1	2	3	4	5	6	7
Never	Rarely	Occas.	Sometimes	Often	Usually	Always

	TRIED		RELIEF						
	YES	NO	1	2	3	4	5	6	7
a. prescription medication	YES	NO	1	2	3	4	5	6	7
b. non-prescription medication	YES	NO	1	2	3	4	5	6	7
c. professional massage	YES	NO	1	2	3	4	5	6	7
d. chiropractic manipulation	YES	NO	1	2	3	4	5	6	7
e. physical therapy	YES	NO	1	2	3	4	5	6	7
f. relaxation training	YES	NO	1	2	3	4	5	6	7
g. biofeedback	YES	NO	1	2	3	4	5	6	7
h. psychotherapy/counseling	YES	NO	1	2	3	4	5	6	7
i. allergy shots	YES	NO	1	2	3	4	5	6	7
j. hospitalization	YES	NO	1	2	3	4	5	6	7
k. dental bite correction	YES	NO	1	2	3	4	5	6	7
l. botox injection	YES	NO	1	2	3	4	5	6	7
m. Other (please describe): _____	YES	NO	1	2	3	4	5	6	7

5. Are you currently or have you ever taken PRESCRIPTION MEDICATIONS for your headaches? YES NO

If YES: Please indicate which medications you have taken for headache IN THE PAST and which ones you ARE TAKING NOW for headache.

<u>BRAND NAME</u>	<u>(generic name)</u>	<u>Past</u>	<u>Now</u>	<u>BRAND NAME</u>	<u>(generic name)</u>	<u>Past</u>	<u>Now</u>
DARVOCET-N.....	(propoxyphene)	___	___	TOLECTIN.....	(tolmetin)	___	___
DARVON.....	(propoxyphene)	___	___	TOLFENOMIC ACID.....	(tolfenomic acid)	___	___
DEMEROL.....	(meperidine)	___	___	TORADOL.....	(ketorolac)	___	___
DILAUDID.....	(hydromorphone)	___	___	TRILISATE.....	(salicylic acid)	___	___
DOLOPHINE.....	(methadone HCL)	___	___	VIOXX.....	(rofecoxib)	___	___
DURAGESIC PATCH.....	(fentanyl)	___	___	VOLTARIN.....	(diclofenac sodium)	___	___
MEPERGAN.....	(meperidine HCl)	___	___	XEFO.....	(lornoxicam)	___	___
MORPHINE SULPHATE.....	(morphine sulphate)	___	___	BELLERGA-S.....	(ergotamine)	___	___
MS CONTIN.....	(morphine sulphate)	___	___	CAFERGOT PB.....	(ergotamine)	___	___
NUBAIN.....	(nalpuphine HCl)	___	___	CAFERGOT.....	(ergotamine)	___	___
STADOL.....	(butorphanol)	___	___	D.H.E. 45.....	(dihydroergotamine)	___	___
ANEXSIA.....	(hydrocodone)	___	___	ERGOMAR.....	(ergotamine)	___	___
BANCAP.....	(hydrocodone)	___	___	ERGOSTAT.....	(ergotamine)	___	___
DARVOCET-N 50 or 100.....	(propoxyphene)	___	___	METHERGINE.....	(methylergonovine)	___	___
DARVON COMPOUND.....	(propoxyphene)	___	___	SANSERT.....	(methysergide)	___	___
EMPIRIN w/ CODEINE.....	(codeine)	___	___	TR-DHE.....	(dihydroergotamine)	___	___
EMPRACET w/ CODEINE.....	(codeine)	___	___	UTERGIN.....	(methylergometrine)	___	___
HY-PHEN.....	(hydrocodone)	___	___	WIGRAINE.....	(ergotamine)	___	___
LORCET.....	(propoxyphene HCl)	___	___	AMERGE.....	(naratriptan)	___	___
LORTAB.....	(hydrocodone)	___	___	FROVA.....	(froatriptan)	___	___
MIDRID.....	(isometheptine)	___	___	IMIGRAN.....	(sumatriptan)	___	___
OXYCONTIN.....	(oxycodone)	___	___	IMITREX.....	(sumatriptan)	___	___
PERCOCET.....	(oxycodone)	___	___	MAXALT.....	(rizatriptan)	___	___
PERCODAN.....	(oxycodone)	___	___	RELPAK.....	(eletriptan)	___	___
PERCOGESIC w/ CODEINE.....	(codeine)	___	___	TRIPT-OH.....	(oxytryptan)	___	___
SYNALGOS.....	(dihydrocodeine)	___	___	ZOMIG.....	(zolmitriptan)	___	___
TALWIN COMPOUND.....	(pentazocine)	___	___	FLEXERIL.....	(cyclobenzaprine)	___	___
TYLENOL w/ CODEINE.....	(codeine)	___	___	NORFLEX.....	(orphenadrine)	___	___
TYLOX.....	(oxycodone)	___	___	NORGESIC.....	(orphenadrine)	___	___
VICODIN.....	(hydrocodone)	___	___	PARAFLEX.....	(chlorzoxazone)	___	___
WYGESIC.....	(propoxyphene)	___	___	PARAFON FORTE.....	(chlorzoxazone)	___	___
XYLOCAINE.....	(lidocaine IN)	___	___	ROBAXIN.....	(methocarbamol)	___	___
ANAPROX.....	(naproxen sodium)	___	___	SOMA COMPOUND.....	(carisoprodol)	___	___
ANSAID.....	(flurbiprofen)	___	___	SOMA COMPOUND w/codeine.....	(carisoprodol)	___	___
CATAFLEM.....	(diclofenac)	___	___	APTIN.....	(alprenolol)	___	___
CELEBREX.....	(celecoxib)	___	___	BLOCKADREN.....	(timolol)	___	___
CLINORIL.....	(sulindac)	___	___	CORGARD.....	(nadolol)	___	___
DOLOBID.....	(diflunisal)	___	___	INDERAL.....	(propranolol)	___	___
EASPRIN.....	(salicylic acid)	___	___	INDERIDE.....	(propranolol)	___	___
FELDENE.....	(piroxicam SL)	___	___	LOPRESSOR.....	(metoprolol)	___	___
INDOBUFEN.....	(indobufen)	___	___	OXYPRENOLOL.....	(oxypropenolol)	___	___
INDOMETHACIN.....	(indomethacin)	___	___	PRACTOLOL.....	(practolol)	___	___
KETOROLAC.....	(toradol)	___	___	SECTRAL.....	(acebutolol)	___	___
LODINE.....	(etodolac)	___	___	TENORMIN.....	(atenolol)	___	___
MECLOMEN.....	(meclofenamate)	___	___	VISKEN.....	(pindolol)	___	___
MOTRIN.....	(ibuprofen)	___	___	ZEBETA.....	(bisoprolol)	___	___
NALFON.....	(fenoprofen)	___	___				
NAPROSYN.....	(naproxen sodium)	___	___				
ORUDIS.....	(ketoprofen)	___	___				
PONSTEL.....	(mefenamic acid)	___	___				

5. (continued)

Please indicate which medications you have taken for headache IN THE PAST and which ones you ARE TAKING NOW for headache.

<u>BRAND NAME</u>	<u>(generic name)</u>	<u>Past</u>	<u>Now</u>	<u>BRAND NAME</u>	<u>(generic name)</u>	<u>Past</u>	<u>Now</u>
CATAPRES.....	(clonidine)	___	___	KLONOPIN.....	(clonazepam)	___	___
TENEX.....	(guanfacine)	___	___	LIBRAX.....	(chlor diazepoxide)	___	___
ADALAT.....	(nifedipine)	___	___	LIBRIUM.....	(chlor diazepoxide)	___	___
CALAN.....	(verapamil HCl)	___	___	TRANXENE.....	(clorazepate)	___	___
CARDENE.....	(nicardipine)	___	___	VALIUM.....	(diazepam)	___	___
CARDIZEM.....	(diltiazem)	___	___	XANAX.....	(alprazolam)	___	___
CYCLOSPASMOL.....	(cycandelate)	___	___	RESTORIL.....	(temazepam)	___	___
ISOPTIN.....	(verapamil)	___	___	REGLAN.....	(metoclopramide)	___	___
NIMOTOP.....	(nimodipine)	___	___	THORAZINE.....	(chlorpromazine)	___	___
PROCARDIA.....	(nifedipine)	___	___	COMPAZINE.....	(prochlorperazine)	___	___
SIBELIUM.....	(funarizine)	___	___	HALDOL.....	(haloperidol)	___	___
CELEXA.....	(citalopram)	___	___	TIGAN.....	(trimethobenzamide)	___	___
FEMOXETINE.....	(femoxetine)	___	___	PHENERGAN.....	(promethazine)	___	___
LUVOX.....	(fluvoxamine)	___	___	AXOTAL.....	(butalbital)	___	___
MIANSERIN.....	(mianserin)	___	___	ESGIC.....	(butalbital)	___	___
OPRIMOL.....	(opipramol)	___	___	FIORICET.....	(butalbital)	___	___
PAXIL.....	(paroxetine)	___	___	FIORICET w/ codeine.....	(butalbital)	___	___
PROZAC.....	(fluoxetine)	___	___	FIORINAL.....	(butalbital)	___	___
SERZONE.....	(nefazodone)	___	___	FIORINAL w/ codeine.....	(butalbital)	___	___
ZOLOFT.....	(sertraline)	___	___	PHRENALIN.....	(butalbital)	___	___
ADAPIN.....	(doxepin)	___	___	TRIAD.....	(butalbital)	___	___
ANAFRANIL.....	(clomipramine)	___	___	PERIACTIN.....	(cyproheptadine)	___	___
ASENDIN.....	(amoxapine)	___	___	SANDOMIGRAN.....	(pizotifen)	___	___
DESYREL.....	(trazadone)	___	___	DOPERGIN.....	(lisuride)	___	___
EFFEXOR.....	(venlafazine HCl)	___	___	IPRAZOCHROME.....	(iprazochrome)	___	___
ELAVIL.....	(amitriptyline)	___	___	NAVOBAN.....	(tropisetron)	___	___
ENDEP.....	(amitriptyline)	___	___	EQUAGESIC.....	(meprobamate)	___	___
LIMBITROL.....	(amitriptyline)	___	___	ESTRACE.....	(estradiol)	___	___
NARDIL.....	(phenelzine)	___	___	FEVERFEW.....	(tanacetum parthenium)	___	___
NORPRAMINE.....	(desipramine)	___	___	MAGNACAPS.....	(magnesium)	___	___
PAMELOR.....	(nortriptyline)	___	___	MAG-OX 400.....	(magnesium)	___	___
REMERON.....	(mirtazepine)	___	___	MIDRIN.....	(isometheptine)	___	___
SINEQUAN.....	(doxepin)	___	___	MIGRALAM.....	(isometheptine)	___	___
TOFRANIL.....	(imipramine)	___	___	PREMARIN.....	(estradiol)	___	___
VIVACTIL.....	(protriptyline)	___	___	VITAMIN B2.....	(riboflavin)	___	___
WELLBUTRIN.....	(bupropion HCl)	___	___	other:.....		___	___
ESKALITH.....	(lithium carbonate)	___	___	other:.....		___	___
LITHOBID.....	(lithium carbonate)	___	___	other:.....		___	___
VISTARIL.....	(hydroxyzine HCl)	___	___	other:.....		___	___
DILANTIN.....	(phenoin sodium)	___	___	other:.....		___	___
TEGRETAL.....	(carbamazepine)	___	___				
DEPAKOTE.....	(divalproex sodium)	___	___				
DEPAKENE.....	(sodium valproate)	___	___				
NEURONTIN.....	(gabapentin)	___	___				
GABITRIL.....	(tiagabine)	___	___				
TOPAMAX.....	(topiramate)	___	___				
TRILEPTAL.....	(oxcarbazepine)	___	___				

- 6. On the average, how many headache-free days do you have per week? _____
- 7. On the average, how many days per month do you have a headache? _____
- 8. On the average, how many hours per day do your headaches last? _____
- 9. How long have you been having problem headaches? (years, months) _____

Use the following *Headache Intensity Scale* to answer the next three questions:

0	1	2	3	4	5	6	7	8	9	10
No	*	Slightly	*	Mildly	*	Painful	*	Very	*	Extremely
Headache		Painful		Painful				Painful		Painful

- (0) No Headache
- (1)
- (2) Slightly Painful -- I only notice my headache when I focus my attention on it.
- (3)
- (4) Mildly Painful -- I can ignore my headache most of the time.
- (5)
- (6) Painful -- My headache is painful, but I can continue what I am doing.
- (7)
- (8) Very Painful -- My headache makes concentration difficult, but I can perform undemanding tasks.
- (9)
- (10) Extremely Painful - My headache is so painful I can't do anything.

10. What is the average intensity of your headache during a typical headache day?

0 1 2 3 4 5 6 7 8 9 10

11. What is the highest intensity your headache reaches in a typical week?

0 1 2 3 4 5 6 7 8 9 10

12. On average, how intense have your headaches been in the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

13. On average, how intense have your headaches been in the last 30 days?

0 1 2 3 4 5 6 7 8 9 10

Use the following scale to answer questions 7 & 8:

0	1	2	3	4	5	6	7	8	9	10
Very Poor	*	Poor	*	Fair	*	Good	*	Very Good	*	Excellent

7. On average, what has your sleep quality been in the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

8. On average, what has your sleep quality been in the last 30 days?

0 1 2 3 4 5 6 7 8 9 10

PLEASE GO ON TO THE NEXT PAGE

V. HEADACHE TRIGGER QUESTIONNAIRE

never or almost never	a few times per year	less than 1 time per month	1 to 3 times per month	1 or 2 times per week	3 times per week or more	nearly every day or daily
0	1	2	3	4	5	6

For each item below, please circle **YES** if you believe it can *sometimes* trigger a headache for you, **NO** if you believe it is unlikely to trigger a headache, and **UNSURE** if you are not sure if it can trigger a headache.

FOOD/BEVERAGES: Using the 0 to 6 scale above, please indicate how often you typically consume the following foods and beverages. Then circle *Yes*, *No*, or *Unsure* for each item.

	<u>How Often</u>							<u>Headache Trigger</u>			
1. Red wine	0	1	2	3	4	5	6	.....	Yes	No	Unsure
2. Other alcoholic beverages.....	0	1	2	3	4	5	6	.....	Yes	No	Unsure
3. Aged cheese (cheddar, blue cheese)	0	1	2	3	4	5	6	.....	Yes	No	Unsure
4. Foods with MSG (Chinese food, 'Accent').....	0	1	2	3	4	5	6	.....	Yes	No	Unsure
5. Chocolate	0	1	2	3	4	5	6	.....	Yes	No	Unsure
6. Caffeinated beverages	0	1	2	3	4	5	6	.....	Yes	No	Unsure
7. Nuts or peanut butter.....	0	1	2	3	4	5	6	.....	Yes	No	Unsure
8. Cured or processed meats (hot dogs, bacon, sausage)	0	1	2	3	4	5	6	.....	Yes	No	Unsure

BEHAVIOR PATTERNS: Using the 0 to 6 scale above, please indicate how often you engage in the following behavior. Then circle *Yes*, *No*, or *Unsure* for each item.

	<u>How Often</u>							<u>Headache Trigger</u>			
9. Eating less food while dieting	0	1	2	3	4	5	6	.....	Yes	No	Unsure
10. Delaying a meal.....	0	1	2	3	4	5	6	.....	Yes	No	Unsure
11. Skipping a meal.....	0	1	2	3	4	5	6	.....	Yes	No	Unsure
12. Snacking instead of having a meal	0	1	2	3	4	5	6	.....	Yes	No	Unsure
13. Sleeping or napping <i>more</i> than usual.....	0	1	2	3	4	5	6	.....	Yes	No	Unsure
14. Sleeping or napping <i>less</i> than usual	0	1	2	3	4	5	6	.....	Yes	No	Unsure
15. Having insomnia or other sleep disturbances	0	1	2	3	4	5	6	.....	Yes	No	Unsure
16. Physically exercising to exhaustion	0	1	2	3	4	5	6	.....	Yes	No	Unsure
17. Feeling overly fatigued	0	1	2	3	4	5	6	.....	Yes	No	Unsure

MOOD STATES: Using the 0 to 6 scale above, please indicate how often you experience the following mood states. Then circle *Yes*, *No*, or *Unsure* for each item.

	<u>How Often</u>							<u>**Headache Trigger</u>			
18. Feeling <i>moderately</i> pressured or stressed.....	0	1	2	3	4	5	6	.....	Yes	No	Unsure
19. Feeling <i>very</i> pressured or stressed.....	0	1	2	3	4	5	6	.....	Yes	No	Unsure
20. Feeling <i>moderately</i> upset or unhappy	0	1	2	3	4	5	6	.....	Yes	No	Unsure
21. Feeling <i>very</i> upset or unhappy	0	1	2	3	4	5	6	.....	Yes	No	Unsure
22. Feeling <i>moderately</i> irritable or angry	0	1	2	3	4	5	6	.....	Yes	No	Unsure
23. Feeling <i>very</i> irritable or angry.....	0	1	2	3	4	5	6	.....	Yes	No	Unsure
24. Feeling <i>moderately</i> tense or anxious	0	1	2	3	4	5	6	.....	Yes	No	Unsure
25. Feeling <i>very</i> tense or anxious	0	1	2	3	4	5	6	.....	Yes	No	Unsure

** Remember, a headache can be triggered either *during* the mood state or within a day or so *after* the mood state has passed (i.e., a "let down headache").

Headache Trigger Questionnaire (page 2 of 2)

ENVIRONMENTAL FACTORS: Please circle *Yes*, *No*, or *Unsure* for each item.

- | | | | |
|--|-----|----|--------|
| 1. Odors | Yes | No | Unsure |
| 2. Smoke | Yes | No | Unsure |
| 3. Chemical vapors | Yes | No | Unsure |
| 4. Strong perfumes or colognes | Yes | No | Unsure |
| 5. Bright light | Yes | No | Unsure |
| 6. Flickering light | Yes | No | Unsure |
| 7. Glare | Yes | No | Unsure |
| 8. Hot environment | Yes | No | Unsure |
| 9. Cold environment | Yes | No | Unsure |
| 10. Loud noise | Yes | No | Unsure |
| 11. Weather or barometric pressure changes | Yes | No | Unsure |

FOR WOMEN ONLY: Do you have menstrual periods? **YES NO**

If Yes, are you likely to experience more headaches or more severe headaches during any of the following times?

- | | | | |
|--|-----|----|--------|
| 1. Just before menstruation begins | Yes | No | Unsure |
| 2. During menstruation | Yes | No | Unsure |
| 3. Just after menstruation ceases | Yes | No | Unsure |
| 4. Mid-cycle (about the time of ovulation) | Yes | No | Unsure |

PLEASE GO ON TO THE NEXT PAGE

VI. HAB

Use the following scale to estimate how much of the time you do each of the following when you have a headache:

 1 2 3 4 5 6 7
 Never Rarely Occas. Sometimes Often Usually Always

- 1 2 3 4 5 6 7 1. Take time off work, housework, etc.
- 1 2 3 4 5 6 7 2. Avoid or minimize physical exertions/activity.
- 1 2 3 4 5 6 7 3. Avoid or reduce bright lights.
- 1 2 3 4 5 6 7 4. Avoid or reduce loud noise.
- 1 2 3 4 5 6 7 5. Avoid or reduce social contacts.

- 1 2 3 4 5 6 7 6. Go to see a physician.
- 1 2 3 4 5 6 7 7. Go to the emergency room.
- 1 2 3 4 5 6 7 8. Try to focus on something other than the headache.
- 1 2 3 4 5 6 7 9. Take medication.
- 1 2 3 4 5 6 7 10. Close your eyes.

- 1 2 3 4 5 6 7 11. Lie down and rest.
- 1 2 3 4 5 6 7 12. Relax.
- 1 2 3 4 5 6 7 13. Sleep.
- 1 2 3 4 5 6 7 14. Tell someone that you have a headache.
- 1 2 3 4 5 6 7 15. Slump, slouch, or find it hard to stand up.

- 1 2 3 4 5 6 7 16. Hold or press your head, neck, or temples.
- 1 2 3 4 5 6 7 17. Use massage, cold compress, etc. to reduce pain.
- 1 2 3 4 5 6 7 18. Show that it hurts by expression (grimace, squint, frown)
- 1 2 3 4 5 6 7 19. Show that it hurts through sound (moan, cry out , sigh, etc.)
- 1 2 3 4 5 6 7 20. Go on with usual activities despite the headache.

Using the same scale, indicate how much of the time your family, friends, or co-workers do each of the following when they know that you have a headache:

- 1 2 3 4 5 6 7 1. Express concern.
- 1 2 3 4 5 6 7 2. Do things for you.
- 1 2 3 4 5 6 7 3. Avoid you.
- 1 2 3 4 5 6 7 4. Ignore you.
- 1 2 3 4 5 6 7 5. Offer help.
- 1 2 3 4 5 6 7 6. Get angry at you.
- 1 2 3 4 5 6 7 7. Get angry at the situation (the headache).
- 1 2 3 4 5 6 7 8. Other (describe) _____
- 1 2 3 4 5 6 7 9. _____
- 1 2 3 4 5 6 7 10. _____

PLEASE GO ON TO THE NEXT PAGE

VII. WOMEN ONLY

******* THIS SECTION TO BE COMPLETED BY WOMEN ONLY *******

1. How old were you when you began menstruating? _____
2. Are you pregnant at the present time? YES NO
3. Have you ever been pregnant? YES NO
 - 3a. If YES, did your headaches change during pregnancy? (check only one)
 - Headaches were not a problem for me at that time _____
 - Yes, the headaches disappeared completely..... _____
 - Yes, the headaches improved somewhat _____
 - No, the headaches were not affected by the pregnancy _____
 - Yes, the headaches got somewhat worse _____
 - Yes, the headaches became much more intense _____
4. Are you currently or have you ever taken oral contraceptives (birth control pills), depo-provera (shot), Norplant? YES NO
 - If YES, what type do/did you take? _____
 - 4a. If YES, how long did you take them? _____ years _____ months
 - 4b. Did oral contraceptives change your headaches in any way? (check one)
 - Headaches were not a problem for me at that time _____
 - Yes, my headaches disappeared completely..... _____
 - Yes, my headaches improved somewhat _____
 - No, my headaches were not affected _____
 - Yes, my headaches got somewhat worse.... _____
 - Yes, my headaches became much more intense _____
 - 4c. Are you still taking oral contraceptives? YES NO
 - If NO, When did you stop? _____
 - Why did you stop? _____
5. Have you ever used female hormone supplements (e.g., Premarin tablets or vaginal creams, estrone, or estrogens)? YES NO

If YES, please answer the following:

- 5a. How long did you take them? _____ years _____ months
- 5b. Did the hormone supplements change your headaches : (check one)
 - Headaches were not a problem for me at that time _____
 - Yes, my headaches disappeared completely..... _____
 - Yes, my headaches improved somewhat..... _____
 - No, my headaches were not affected _____
 - Yes, my headaches got somewhat worse.... _____
 - Yes, my headaches became much more intense _____
- 5c. Are you currently taking the hormone supplements? YES NO
 - If No: When did you stop? _____
 - Why did you stop? _____

*****PLEASE GO ON TO THE NEXT PAGE*****

6. About when did you last have a gynecological or pelvic exam? _____
7. About how often do you see a gynecologist? _____

8. Have you ever experienced any of the following:

- YES NO Menstrual periods stopped for 12 months or more
- YES NO Hot flashes (flushes)
- YES NO Irregular menstrual periods
- YES NO Fertility problems
- YES NO Hormone imbalance
- YES NO Endometriosis
- YES NO Excessive, very heavy menstrual bleeding
- YES NO Pelvic inflammatory disease
- YES NO Ovarian cysts
- YES NO Severe pain with menstruation over at least 6 cycles which prevented you from going to work or school
- YES NO Other menstrual problems (please specify): _____
- YES NO _____
- YES NO Other gynecological problems (please specify): _____
- YES NO _____

9. Do you still have menstrual periods? YES NO

If YES, Answer questions 10-13, Skip questions 14-16.
If NO, Skip question 10-13 and Answer questions 14-16.

10. Can you usually predict when your period will begin by looking at a calendar? YES NO

11. How many days do your cycles usually last (from the start of one period to the start of the next period) ? _____

12. If you have unusual or extreme symptoms associated with your periods, please describe them:

13. Have you noticed any relationship between your migraines and your menstrual cycle?
If YES please describe in terms of proximity of migraine to menstrual cycle phases:

14. How much do the number of days in your cycle vary from month to month?

- _____ 0-2 days
- _____ 3-4 days
- _____ 5-7 days
- _____ More than 7 days

15. How many days does the menstruation portion of your cycle usually last? _____

16. How many times have you been pregnant, if ever? _____

17. Have you ever experienced a miscarriage? Yes _____ No _____

IF YOU HAVE NOT HAD MENSTRUAL PERIODS IN THE PAST 12 MONTHS,
PLEASE ANSWER 18-20:

18. What was the approximate date of your last menstrual period? _____

19. Have your periods stopped due to :
_____ menopause (change of life)
_____ hysterectomy
_____ illness (please specify illness): _____
_____ other (please specify reason): _____

20. Have you had a hysterectomy? YES NO

If YES,

15a. When did you have the surgery? _____

15b. What was the reason for the surgery? _____

15c. Were your ovaries removed? _____ No
_____ One ovary removed
_____ Two ovaries removed
_____ Don't know