

Northeastern Migraine Surgery
David A. Branch, MD
55 Broadway
Bangor, ME 04401
(207)947-5657 or 1-888-501-1855
Fax (207)947-1894
lori@bangorplastic.com

Instructions: By completing this form, you are providing Dr. Branch and Northeastern Migraine Surgery with valuable information about your migraine suffering and how best to treat it. Please complete this form and mail, fax or e-mail it back to us before your consultation. Thank you very much.

Patient Name: _____ **Date:** _____

DOB: _____ **Occupation:** _____

Marital Status: Married Single Divorced Widowed

Race: Caucasian Hispanic African American Other _____

Education Level: HS Grad 2 yr degree 4 yr degree Advanced degree

1. How old were you when your migraine headaches started? _____
2. How many migraine headaches do you experience per month? _____ On average.
3. How many regular headaches do you have per month? _____ On average.
4. Do any of your family members have migraine headaches?
 No Yes, If "yes", explain who: _____
5. How long do your migraine headache(s) last, with medication, on average?
No more than 2 hours 3-4 hours 5-12 hours 12-24 hours several days 1 week+
6. How long do your migraine headache(s) last, without medication, on average?
No more than 2 hours 3-4 hours 5-12 hours 12-24 hours several days 1 week+
7. How painful are your migraine headaches, on a scale from 1-10, 1 being mild, 10 being severe: _____.
8. How many times in the last month have you had nausea? _____ vomiting? _____
9. Where are your migraine headaches usually located? (Circle all that apply).
Behind right eye Behind left eye Behind both eyes Both temples
Right temple Left temple Above right eyebrow Above left eyebrow
Back of head on right Back of head on left Back of head on both sides Other _____
10. If you know, where do your migraine headaches usually start? _____

11. How would you describe your migraine headaches?

- Throbbing/pounding
- Ache/pressure
- Like a tight band
- Dull
- Other, describe _____

12. Do any of the following occur before/during/after your migraine headaches? (Check all that apply).

- Nausea
- Bothered by light/noise
- Eyelid puffy
- Feeling lightheaded
- Difficulty Concentrating
- Runny nose
- Vomiting
- Blurred/double vision
- Eyelid droops
- Numbness
- Tingling
- Speech Difficulty
- Diarrhea
- Sparkling/flashing/colored lights
- Loss of vision
- Weakness of arm or leg
- Loss of consciousness

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

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

14. Do any of the following bring on your migraine headaches or make them worse?

(Check all that apply)

- Stress
- Bright Sunshine
- Weather change
- Letdown (after stress)
- Air travel
- Loud noise
- Heavy lifting
- Fatigue
- Certain smells or perfume
- Missed meals
- Sexual activity
- Coughing, straining, bending over
- Certain foods
- Other _____

15. If you are a female, do your migraine headaches change with the following?

- Menstrual periods
- Birth Control pills
- Pregnancy
- Other hormonal drugs

16. Have you ever been diagnosed to have any health disorder (high blood pressure, asthma, heart disease, gastric ulcers)? No Yes, Please list: _____

17. Have you had your migraine headaches evaluated by a neurologist?

- a. No Yes If "yes", when, where, and by whom? _____

18. List all past tests you had for your migraine headaches: _____

19. List all past treatment(s) for your migraine headaches: _____

20. Are you taking any prescription drugs to treat your migraine headaches? Yes No

If yes, list the medications: _____

21. How many times in the last month have you taken the prescribed medications? _____

22. Are you taking any over-the-counter medications to treat you migraine headaches

- No Yes If yes, list medications: _____

23. How many times in the last month have you taken the over-the-counter medications? _____
24. What is your estimated cost per month of your migraine headache medications and visits to the physician?

25. How much of these medical expenses are covered by your health insurance? _____
26. How would you rate your general health in the last month?
 Excellent Good Fair Poor
27. To What extent did the migraine affect the quality of your life?
 Not at all Very little Moderately Fairly significantly Extremely
28. How many days have you missed from work or other activities due to your migraine headaches? _____

29. Do your migraine headaches awaken you at night? € Never € Occasionally € Often
 Do you wake in the morning with a Migraine headache? € Never € Occasionally € Often

NASAL EVALUATION:

30. Have you ever had nasal trauma or surgery? _____
31. Do you have breathing difficulties from either nostril? _____
32. Do you have sleep apnea? _____
33. Do you snore? _____
34. Do you have a history of sinus headaches? _____
35. Do you have a history of sinus infections? _____
36. Are you a mouth breather? _____
37. Do get any relief with sprays, humidifiers, or antihistamines? _____
38. Do you wake at night with breathing problems? _____
39. Do your migraine headaches get worse with weather changes? _____

NECK EVALUATION:

40. Have you ever had any neck trauma or surgery? _____
41. Does a neck massage benefit or worsen your migraine headache? _____