This form can help you and your doctor improve the management of your headaches

Do You Suffer From

headaches?

MIDAS 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.

	Question	Answer	
1	On how many days in the last 3 months did you miss work or school because of your headaches?		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)*		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 you counted in question 3 where you did not do household work)*		days
5	On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?		days
	TOTAL		days
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)*		days
B	On a scale of 0–10, on average how painful were these headaches? *(Where 0 = no pain at all, and 10 = pain as bad as it can be)*		

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Your MIDAS score...

Grading system for the MIDAS Questionnaire:

Grade	*Definition*	*Score*
I	*Minimal or infrequent disability*	*0–5*
II	*Mild or infrequent disability*	*6–10*
III	*Moderate disability*	*11–20*
IV	*Severe disability*	*21+*

The MIDAS Questionnaire provides valuable information to help your physician recommend a suitable management strategy for your headaches. We recommend that you take the completed Questionnaire to your physician to obtain suitable treatment.

MIDAS
www.midas-migraine.net

The MIDAS programme is sponsored by AstraZeneca

HIT-6™
(VERSION 1.1)

HEADACHE IMPACT TEST™

This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

To complete, please circle one answer for each question.

1 When you have headaches, how often is the pain severe?

Never | Rarely | Sometimes | Very Often | Always

2 How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

Never | Rarely | Sometimes | Very Often | Always

3 When you have a headache, how often do you wish you could lie down?

Never | Rarely | Sometimes | Very Often | Always

4 In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

Never | Rarely | Sometimes | Very Often | Always

5 In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

Never | Rarely | Sometimes | Very Often | Always

6 In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

Never | Rarely | Sometimes | Very Often | Always

COLUMN 1 (6 points each)	+	COLUMN 2 (8 points each)	+	COLUMN 3 (10 points each)	+	COLUMN 4 (11 points each)	+	COLUMN 5 (13 points each)

To score, add points for answers in each column.

Please share your HIT-6 results with your doctor.

Total Score

Higher scores indicate greater impact on your life.

Score range is 36-78.

HIT-6™ US (English) Version 1.1

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HEADACHE QUESTIONNAIRE

Please answer the following questions Please give necessary details for "yes" answers. We realize that this form is long, but when it is filled out carefully it allows us to devote more time to examining you.

Description of Present Illness

1a. My headaches started on:

1b. I get headaches about every: day week month three-months year (circle 1)

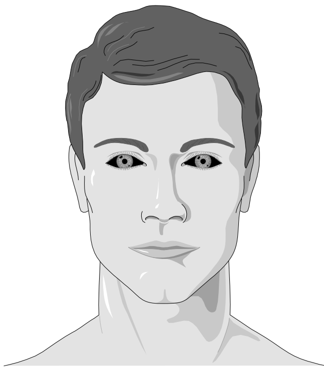
1c. My headaches last: seconds minutes hours days (circle 1)

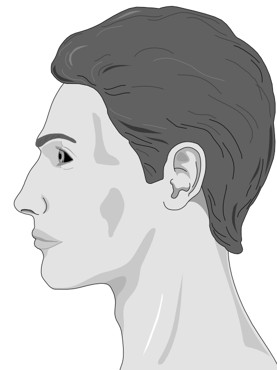
1d. Describe the head pain you experience (circle one or several)

throbbing	pulsating	pounding	constant
tight	squeezing	pressure	sharp
grinding	vise-like	hat-band	tender

other:

1e: My headaches are located (mark location, one or several)





Associations

2. Headache is accompanied by (circle)

diarrhea

dizziness

drooping eye lid

facial tenderness

fever

flushing on one side of the face

light sensitivity

loss of consciousness

nausea or vomiting

neck stiffness

noise sensitivity

numbness in face/arm/leg

red, tearing eye

runny nose/congestion

swelling of ankles

speech disturbance

visual disturbances

weakness in face/arm/leg

other:

HEADACHE QUESTIONNAIRE

3A. Is your head pain triggered by any of the following: (circle)

other:

Alcohol

Barometric pressure or weather

Bending over

Blood Pressure

Certain foods (such as cheese or Chocolate)

Colds

Coughing

Depression, anxiety, nerves, or stress

Exertion

Fatigue

Heat, hot showers

Head movement

Menstrual periods

Missing a meal

Monosodium glutamate (MSG)

Odors

Salt

Sex

Seasons

Swallowing

Sleep or Lack of sleep

Time of day

HEADACHE QUESTIONNAIRE

3A. Is your head pain relieved by any of the following: (circle)

Cold compresses

Eating

Heat

Massage

Medication (which ones ?)

Moving around

Relaxation

Sleep

Vomiting

Other

HEADACHE QUESTIONNAIRE

Life Style

4. Habits

How many alcoholic drinks per day ?	____________________	
How many caffeinated drinks per day	____________________	
How many hours do you sleep per day ?	____________________	
Do you smoke cigarettes, cigars or pipes ?	No	Yes
Are you currently involved in litigation with respect to any medical problems ?	No	Yes
Are you usually highly stressed ?	No	Yes
Do you usually eat 3 meals/day ?	No	Yes

5. Injuries (Circle, date)

head

neck (for example whiplash)

dental work preceding onset of headache ?

6. Exposures or Infections (Circle, date)

Carbon Monoxide (car or house)

Venereal Disease or Syphilis ?

Tuberculosis or Cysticercosis ?

HEADACHE QUESTIONNAIRE

MEDICATIONS

7a. What are your current medications, include hormones, birth control pills, vitamins, etc. (Name and amount/day)?

7c. Have you ever taken any of the following medicines for headache : (circle)

Abilify
Adipin
Acetaminophen
Advil
Alleve
AlkaSeltzer
Amerge (triptan)
Amitriptyline
Anacin
Anafranil
Antihistamines
Asendin
Aspirin
Axert (triptan)
Axotal
Aventyl
Baclofen
Bellergal
Beta-blocker
Blockadren
Bufferin
Cafergot
Calan (verapamil)
Cardene
Cardizem
Catapres
Corguard
Codeine
Cymbalta
Cyproheptadine
Darvon/Darvocet
Datril
Dapro
Desyril
Dilantin
Decongestants
Demerol
Depakote
DHE
Duradrin
Duragesic
Ecotrin
Effexor
Elavil (amitryptyline)
Empirin
Ergomar (ergot)
Ergostat (ergot)
Esgic
Equigesic
Excedrin
Fentanyl patch
Feverfew
Fiorinal
Fioricet
Flexeril
Gabapentin
Ibuprofen
Imitrex
Inderal (propranolol)
Indocin
Indomethacin
Isoptin
Lamictal
Lexapro
Limbitrol
Lithium
Liorisal
Lopressor
Lortabs
Lorcet
Ludiomil
Lyrica
Magnesium
Marplan
Maxalt (triptan)
Methadone
Mexetil
Micranin
Midol
Midrin
Migranol
Motrin
Naprosyn
Neurontin
Nimodipine
Norflex
Norgesic
Norpramin
Nortriptyline
Nubain
Nuprin
Oxygen
Oxycontin
Pamelor
Panadol
Parafon Forte
Parnate
Paxil
Pertofrane
Percocet
Percodan
Percogesic
Periactin (cyproheptadine)
ohenergan
Phrenilin
Procardia
Propranolol (inderal)
Prozac
Reglan
Relpax (triptan)
Robaxin
Serzone
Sansert
Sinequan
Sinutab
Skelaxin
Soma
Stadol Nasal Spray
Sumatriptin (triptan)
Surmontil
Talwin
Tenormin
Thorazine
Timonol
Topamax
Toprol
Torecan
Trexan
Triavil
Trilifon
Trileptal
Tylox
Tylenol
Tylenol #3 or #4
Vanquish
Venlafaxine (Effexor)
Verapamil (Calan)
Verelan (verapamil)
Viskin
Vivactyl
Vicodin
Wellbutrin
Wigraine
Zomig
Zonegran
Zoloft

Herbal products
Petadolex

HEADACHE QUESTIONNAIRE

Past Medical History, Review of Systems

8. My health has been affected by (circle, date)

General Health Problems

Heart problems

High cholesterol

High or low blood pressure

Diabetes

Palpitations (abnormal or fast beating) of the heart

Cancer

What type

15 lb or more weight loss

Metabolic

Kidney problems, Dialysis

Liver problems

Low sugar (hypoglycemia)

Thyroid disorders

Psychological Troubles

Treatment by a psychiatrist or counselor

Depression or unusual amounts of stress

Panic Attacks

Pain

Pain in back of jaw (TMJ)

Migraine or other headaches

Low Back or Neck Pain

Systemic Diseases

AIDS

Arthritis

Blood diseases, anemia

Skin diseases

Lupus

Fevers or swollen glands

Syphilis or venereal disease

Mononucleosis (Epstein Barr)

Lyme disease

Meningitis

Tuberculosis (TB)

Eye Problems

Crossed eyes, lazy eye

Poor vision in one eye (amblyopia)

Neurological Problems

Bladder problems

Tremor or incoordination

Loss of consciousness (faints or seizures)

Pins and needles, numbness (where)

Muscle weakness (where)

Problems with sexual function

Trouble speaking

Surgery

HEADACHE QUESTIONNAIRE

Family History

9. Are there any **family members** with (circle):

Headaches just like mine

Diabetes

Stroke

Heart disease or high blood pressure

Migraine headaches

Other diseases that run in the family (list)
for malaria)

HEADACHE QUESTIONNAIRE

PREVIOUS STUDIES

11. Have you had any of these tests or procedures ? (circle, date if done, and please note result if known)

OTHER SPECIALTY VISITS

Eye Doctor

Dentist

Chiropracter

NEUROLOGICAL TESTS

Carotid Doppler

Lumbar puncture (spinal fluid examination)

EEG (Brain Wave test for seizures)

GENERAL MEDICAL TESTS

Recent general medical checkup?

Recent general blood tests (Glucose, blood count)

Heart testing (EKG, Stress test, Holter Monitor)

X-RAYS

Cerebral Angiogram

CT scan of the head

MRI, MRA

Sinus X-rays or CT

Neck X-rays, CT or MRI

Chest X-ray

THANK YOU !