



OHIO PLASTIC SURGERY SPECIALISTS

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Migraine Treatment

Please read this information before you begin to fill out the paperwork. Each patient has a different combination of sites for migraine surgery. Our team relies on the information you provide, so please be specific when completing the paperwork in this packet.

Step 1: Fill out the Migraine Log for 4 weeks

This log helps you to begin to really focus where the migraine pain starts from. You will need to try to identify where the pain may begin and where the pain travels. The symptoms you experience and the environmental conditions on the day you have the migraine are very important in order to see the overall picture about your headaches.

Step 2: Fill out the Pre-Treatment Form

Use the migraine log to help you report the specific information about your headaches. You may even begin to see a pattern about your headaches that you did not realize before. Please use this form to provide additional information that you could not put on the migraine log.

Step 3: Fill out the History and Physical Form

Please be specific about any health issues you may have other than your migraine headaches. Provide a list of the prescription and non-prescription medications you are taking. We do need to the dosage and how frequently you take these medications.

Step 4 Fill out the Functional Nose Form

Please pay attention to the question asked. For example, you may not have noticed that you breathe through your mouth instead of your nose. Your family members can help you by watching your daily functions.

If a CT scan has been done please bring the disc of your images to your appointment.

Patient Name _____ Date _____

Functional Nose Information Sheet

Do you have any difficulty breathing through your nose? YES NO

Do you experience sinus headaches? YES NO

Are you a mouth breather? YES NO

Do you experience sore throats and dry chapped lips as a result of mouth breathing? YES NO

Do you snore? YES NO

Do you find that it is harder to breathe through your nose when lying down? YES NO

Do you find it necessary to prop yourself up on more than one pillow? YES NO

Do you use any of the follow?

Nasal irrigations or sprays? YES NO

Vaporizer? YES NO

Humidifier? YES NO

Do you take over the counter nose sprays and decongestants? YES NO
If yes, Please list them:

Do your breathing problems limit your participation in activities such as running, sports, or other forms of exercise? YES NO

Do you find yourself tired during the day as a consequence of waking up at night due to breathing difficulty? YES NO

If yes, does this interfere with your daily function or job performance? YES NO

Have you seen a medical doctor for treatment of this condition? YES NO

Doctor's Name _____

Address _____

Treatment Dates _____

What treatment was advised? _____

Did you experience relief from the treatment? YES NO

**Pre Treatment
Migraine Headache Questionnaire**

Name _____ Date _____

(H) Tel _____ (W) Tel _____

Date of Birth _____ Female Male

Marital Status: Married Single Divorced Widowed

Race: Caucasian Afr.Amer Hispanic Other _____

Occupation _____ Health Insurance Co. _____

1. How many migraine headaches do you experience per month? _____ on average.

2. How many regular headaches do you have per month? _____ on average.

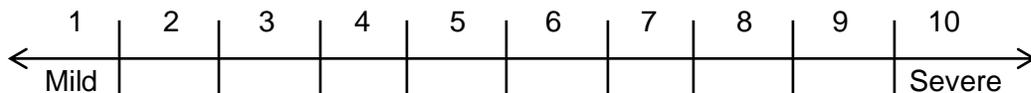
3. How long do your migraine headaches usually last after you take your migraine medicine?

No more than 2 hours 3-4 hours 5-12 hours 12-24 hours Several days 1 week or longer

How long do your migraine headaches usually last if you do not take your migraine medication?

No more than 2 hours 3-4 hours 5-12 hours 12-24 hours Several days 1 week or longer

4. How painful are your migraine headaches? (Circle one number)



5. Where are your migraine headaches usually located? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Behind right eye | <input type="checkbox"/> behind left eye | <input type="checkbox"/> behind both eyes |
| <input type="checkbox"/> Right temple | <input type="checkbox"/> left temple | <input type="checkbox"/> both temples |
| <input type="checkbox"/> Above right eyebrow | <input type="checkbox"/> above left eyebrow | <input type="checkbox"/> above both eyebrows |
| <input type="checkbox"/> Back of head on right | <input type="checkbox"/> back of head on left | <input type="checkbox"/> back of head on both sides |

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

7. How would you describe your migraine headaches? (Check all the apply)

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

8. Do your migraine headaches awaken you at night?

- Never Occasionally Often

9. Do any of the following occur before or during your migraine headaches? (Check all the apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bothered by light/noise | <input type="checkbox"/> Blurred/double vision | <input type="checkbox"/> Sparkling, flashing, or colored lights |
| <input type="checkbox"/> Eyelid puffy | <input type="checkbox"/> Eyelid droops | <input type="checkbox"/> Loss of vision |
| <input type="checkbox"/> Feeling Lightheaded | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Weakness of arm or leg |
| <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Speech difficulty | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Other _____ | |

10. Do any of the following bring on your migraine headaches or make them worse?
(Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Stress (worry, angry) | <input type="checkbox"/> Bright Sunshine | <input type="checkbox"/> Weather change |
| <input type="checkbox"/> Letdown after stress | <input type="checkbox"/> Loud noise | <input type="checkbox"/> Heavy lifting |
| <input type="checkbox"/> Air travel | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Certain smells or perfume |
| <input type="checkbox"/> Missed Meals | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Coughing, straining, bending over |
| <input type="checkbox"/> Certain foods (chocolate, cheese, beer, MSG) | <input type="checkbox"/> Other _____ | |

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Exercise | <input type="checkbox"/> Quiet and darkness |
| <input type="checkbox"/> Hot | <input type="checkbox"/> Massage | <input type="checkbox"/> Warm shower |
| <input type="checkbox"/> Cold compress | <input type="checkbox"/> Pressure over migraine headache area | |
| <input type="checkbox"/> Other _____ | | |

12. If you are female, do you migraine headaches change with the following?
(Check all that apply)

- Menstrual periods Birth control pills Pregnancy Other hormonal drugs

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

- No Yes If "yes", explain (who): _____

14. Have you ever had a head or neck injury requiring medical treatment?

- No Yes If "yes", describe: _____

15. Have you ever been diagnosed to have any health disorder (e.g. high blood pressure, asthma, heart disease, gastric ulcers)?

- No Yes If "yes", please list: _____

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

- No Yes If "yes", please list: _____

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

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

19. Are you taking any *prescription* drugs to treat your migraine headaches?

- No Yes If "yes", list the medications: _____

How many times in the last month have you used *over-the-counter* medications? _____

20. Are you taking *over-the-counter* drugs to treat your migraine headaches?

- No Yes If "yes", list the medications: _____

How many times in the last month have you used *over-the-counter* medications? _____

21. What is your estimated cost per month of your migraine headache medications and visits to the physician? _____

22. How much of these medical expenses are covered by your health insurance? _____

23. How would you rate your general health in the last month? (Check one)

- Excellent Good Fair Poor

24. To what extent do your migraine headaches affect your quality of life? (Check one)

- Extremely Moderately Very little Not at all

Name	Date
	migraine Y(yes) N(no)
	7:00 AM
	9:00AM
	2hrs
	8
	Imitrex 2 tab
	Both
	Right
	0
	0
	cheeks
	Nausea
	Vomiting
	Diarrhea
	Bothered by Light/Noise
	Blurred/double Vision
	Sparkling Lights
	Eyelid Puffy
	Eyelid Droops
	Loss of Vision
	Lightheaded
	Numbness/Tingling
	Weakness arm/leg
	Difficulty concentration
	Runny nose
	Other
	Stress
	Bright Sunshine
	Weather Change
	Letdown after stress
	Loud noise
	Heavy lifting
	Air travel
	Fatigue
	Smells or perfume
	Missed Meals
	Sexual activity
	Straining bending
	Certain foods
	Other notes
Totals	

On Location note Right, Left or Bot The following check box if apply

Did the following bring on or make migraine worse?