OHIO PLASTIC SURGERY SPECIALISTS

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Board Certified Plastic Surgeon

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? If yes, Please list them:	YES	NO
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.

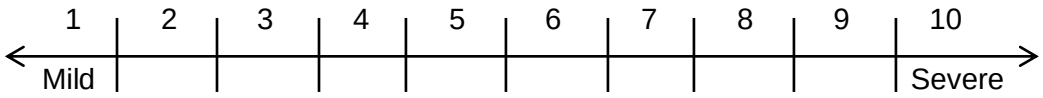
3. How long do your migraine headaches usually last after you take your migraine medicine?

☐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)

☐ 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

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)

☐ Nausea	☐ Vomiting	☐ Diarrhea
☐ Bothered by light/noise	☐ Blurred/double vision	☐ Sparkling, flashing, or colored lights
☐ Eyelid puffy	☐ Eyelid droops	☐ Loss of vision
☐ Feeling Lightheaded	☐ Numbness/tingling	☐ Weakness of arm or leg
☐ Difficulty Concentrating	☐ Speech difficulty	☐ Loss of consciousness
☐ Runny nose	☐ Other _____	

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

☐ Stress (worry, angry) ☐ 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 _____

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

☐ Rest ☐ Exercise ☐ Quiet and darkness
☐ Hot ☐ Massage ☐ Warm shower
☐ Cold compress ☐ Pressure over migraine headache area
☐ 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

Section	Item	Example																												Totals
Name	Date																													
	migraine Y(yes) N(no)	Y																												
	Time Began	7:00 AM																												
	Time Ends	9:00AM																												
	Total time	2hrs																												
	Intensity 0-10	8																												
	Medication & Amount	Imitrex 2 tab																												
On Location note Right, Left or Bot	Behind/around Eye	Both																												
	Temple	Right																												
	Above Eyebrows	0																												
	Back head/Neck	0																												
	Other Location	cheeks																												
The following check box if apply	Nausea																													
	Vomiting																													
	Diarrhea																													
	Bothered by Light/Noise																													
	Blurred/double Vision																													
	Sparking Lights																													
	Eyelid Puffy																													
	Eyelid Droops																													
	Loss of Vision																													
	Lightheaded																													
	Numbness/Tingling																													
	Weakness arm/leg																													
	Difficulty concentration																													
	Runny nose																													
	Other																													
Did the following bring on or make migraine worse?	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																													