

Quayside Dental Headache Centre

Your Name _____

Monthly Migraine Survey

every month we would suggest filling in this quick form to help us get a clearer picture of any improvements in the headaches.

Have you found an improvement in symptoms? If you could score 1 to 10, 10 being the pain you have had previously, how would you score now?

How many times do you get a headache per month? _____

Does it appear on one side or both sides of your head? _____

- | | |
|--|---|
| <input type="checkbox"/> does it pulsate? | <input type="checkbox"/> Are you getting jaw ache or stiffness? |
| <input type="checkbox"/> does it get worse with exercise? | <input type="checkbox"/> Jaw clicking? |
| <input type="checkbox"/> does it stop you from functioning normally? | <input type="checkbox"/> is tooth grinding improving? |

Do you often get neck or back pain? If so give details of whereabouts.

During the run up to the headache, do you get any of the following?

- | | | | |
|--|------------------------------------|---|--|
| <input type="checkbox"/> altered mood | <input type="checkbox"/> yawning | <input type="checkbox"/> excessive sleepiness? | <input type="checkbox"/> food craving e.g. chocolate |
| <input type="checkbox"/> irritable | <input type="checkbox"/> depressed | <input type="checkbox"/> stiff muscles, especially neck | <input type="checkbox"/> constipation |
| <input type="checkbox"/> unusually happy | <input type="checkbox"/> tiredness | <input type="checkbox"/> diarrhea | <input type="checkbox"/> increased urination |

How long before the headache would these symptoms appear? _____

Do you get an aura? If so do you get any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> visual disturbances | <input type="checkbox"/> white flashes | <input type="checkbox"/> tingling in the hands |
| <input type="checkbox"/> zigzag patterns | <input type="checkbox"/> cloudy vision | <input type="checkbox"/> tingling in the feet |
| <input type="checkbox"/> tunnel vision | <input type="checkbox"/> tingling in the face | — |

When finally the headache comes on, do you get any of the following?

- | | |
|---|---|
| <input type="checkbox"/> feeling sick | <input type="checkbox"/> actually sick |
| <input type="checkbox"/> sensitive to light | <input type="checkbox"/> sensitive to sound |
| <input type="checkbox"/> swelling around the face or neck | <input type="checkbox"/> tender forehead to touch |
| <input type="checkbox"/> a vein sticks out on your forehead | <input type="checkbox"/> hands are moist |

How long does the pain last? _____

When the pain wears off, do you get the following?

- | | |
|---|---|
| <input type="checkbox"/> tired | <input type="checkbox"/> washed out |
| <input type="checkbox"/> irritable | <input type="checkbox"/> generally unwell |
| <input type="checkbox"/> depressed | <input type="checkbox"/> unusually happy |
| <input type="checkbox"/> loss of appetite | <input type="checkbox"/> appetite normal |

Do you do anything to try to prevent the pain from coming on in the first place, e.g. avoiding certain foods, drinks and other triggers?

When the pain comes on, do you take any of the following?

Paracetamol

Aspirin

Nurofen

Co-codamol

Apply cold to area

Apply heat to area

Imigran

Migrave

Other over the counter or prescription medication?

Are there any other comments that you feel may be useful?

Monthly migraine survey