

"Migraine Registry" Questionnaire

Identification data	
Name / Surname	
Birth date	
Birth place	
Phone number	
Living place	
Education	
National code	

Past Medical History	
Surgery History	
Neurological Exam	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>

Family history					
Father:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Mother:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sister :	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Brother:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Uncle :	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Uncle :	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aunt :	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Aunt :	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Grandfather :	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Grandmother :	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Other Neurologic disorders (Epilepsy, Stroke, . . .)	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Primary Diagnosis	Migraine <input type="checkbox"/> Tension Type <input type="checkbox"/> Cluster <input type="checkbox"/> Chronic <input type="checkbox"/> Migraine variants <input type="checkbox"/>
Definite Diagnosis	Migraine with Aura <input type="checkbox"/> Migraine without Aura <input type="checkbox"/> Chronic <input type="checkbox"/> Migraine variants <input type="checkbox"/>

"Headache Details"

Onset	Under 6 months	6 - 12 months	After 12 months
Location	Unilateral: Frontal <input type="checkbox"/> Parietal <input type="checkbox"/> Vertical <input type="checkbox"/> Occipital <input type="checkbox"/> Temporal <input type="checkbox"/> Generalized <input type="checkbox"/>		
	Bilateral: Frontal <input type="checkbox"/> Parietal <input type="checkbox"/> Vertical <input type="checkbox"/> Occipital <input type="checkbox"/> Temporal <input type="checkbox"/> Generalized <input type="checkbox"/>		
Severity	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/> Disabling <input type="checkbox"/>
Quality	Pressure <input type="checkbox"/>	Stabbing <input type="checkbox"/>	Needling <input type="checkbox"/> Pulsatile <input type="checkbox"/> Vague <input type="checkbox"/>
Duration	Minutes <input type="checkbox"/>	Hours <input type="checkbox"/>	Days <input type="checkbox"/>
Frequency	Less than 1 time in month <input type="checkbox"/>	2-4 times in month <input type="checkbox"/>	5-8 times in month <input type="checkbox"/>
	more than 9 times in month <input type="checkbox"/>		
Headache Peak	Morning <input type="checkbox"/>	Noon <input type="checkbox"/>	Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> No difference <input type="checkbox"/>
Seasonal Peak	Spring <input type="checkbox"/>	Summer <input type="checkbox"/>	Autumn <input type="checkbox"/> Winter <input type="checkbox"/> No difference <input type="checkbox"/>

Aura	No <input type="checkbox"/>
	Yes: Visual <input type="checkbox"/> Hearing <input type="checkbox"/> Sensory <input type="checkbox"/> Brainstem <input type="checkbox"/>
Prodromal signs	Mood changes <input type="checkbox"/> Personality changes <input type="checkbox"/> Appetite Changes <input type="checkbox"/> Fatigue <input type="checkbox"/> Neck pain <input type="checkbox"/>
Associated Signs	Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vertigo <input type="checkbox"/> Tearing <input type="checkbox"/> Irritability <input type="checkbox"/> Mood disorders <input type="checkbox"/> Photophobia <input type="checkbox"/> Phonophobia <input type="checkbox"/>
Alternative Factors	Sleep <input type="checkbox"/> Rest in dark room <input type="checkbox"/> Exercise <input type="checkbox"/> Massage <input type="checkbox"/> Head banding <input type="checkbox"/> Warm/Cold Compress <input type="checkbox"/>
Affection Function	Normal <input type="checkbox"/> Mild dysfunction <input type="checkbox"/> Severe dysfunction <input type="checkbox"/>

Examinations

Routine Lab Data	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> : No <input type="checkbox"/>
EEG	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> : No <input type="checkbox"/>
Brain CT	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> : No <input type="checkbox"/>
Brain MRI	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> : No <input type="checkbox"/>

Analgesic Drugs	
Prophylactic Drugs	

Referred By: