Patient Name _____ **Date** _____

Please let the receptionist know if your phone, address, e-mail or insurance have changed.

Since the last visit, are you: ☐ Much better ☐ A little better ☐ About the same ☐ A little worse ☐ Much worse

Have you had any of the following problems since your last visit:

- ☐ Change in marital status
- ☐ Change in job/school
- ☐ New illness diagnosed
- ☐ Emotional trauma
- ☐ Change in smoking/drinking/diet
- ☐ Hospitalization/surgery
- ☐ Fatigue
- ☐ Bruising
- ☐ Weight loss _____ lbs, gain _____ lbs
- ☐ Allergic reaction
- ☐ Skin rash
- ☐ Fever/chills
- ☐ High blood pressure
- ☐ Palpitations
- ☐ Breathing difficulty
- ☐ Chest pain
- ☐ Swelling
- ☐ Chronic cough
- ☐ Wheezing
- ☐ Bleeding/bruising
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Nausea/vomiting
- ☐ Joint pain/swelling/redness
- ☐ Muscle aches
- ☐ Sexual dysfunction
- ☐ Breast lumps/discharge
- ☐ Symptoms of menopause
- ☐ Irregular periods
- ☐ PMS
- ☐ Bladder problems
- ☐ Cold extremities
- ☐ Leg/foot cramps
- ☐ Depression
- ☐ Anxiety/panic attacks
- ☐ Change in skin/hair
- ☐ Excessive urination or thirst
- ☐ Insomnia
- ☐ Leg restlessness
- ☐ Daytime sleepiness
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Teeth grinding/clenching
- ☐ Seizures/shaking
- ☐ Headaches
- ☐ Back pain
- ☐ Neck pain
- ☐ Decline in memory
- ☐ Weakness
- ☐ Numbness
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Loss of consciousness
- ☐ Dizziness
- ☐ Dental problems
- ☐ Sinus problems
- ☐ Hoarseness
- ☐ Any other problems not listed

Current prescription and over-the-counter medications and supplements (for all medical conditions).

Patient signature _____

Provider signature_____ **Reviewed with patient on** _____

Continue on the other side

(we may need this information for insurance approvals for drugs and Botox)

Midas Questionnaire | Migraine Disability Assessment

Patient Name _____ **Date** _____

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you. It can also help us get insurance approval for certain treatments.

INSTRUCTIONS: Please answer the following questions about all of your headaches 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.

1. On how many days in the last 3 months did you miss work or school because of your headaches? (If you do not attend work or school enter zero in the space to the right.) . ☐

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. If you do not attend school or work enter zero at right.) . ☐

3. On how many days in the last 3 months did you not do household work because of your headaches? ☐

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 1 where you missed work or school. If you do not attend school or work enter zero at right.) . ☐

5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches? ☐

A. On how many days in the last 3 months did you have a headache (If headache lasted more than 1 day, count each day.). ☐

B. On a scale of 0-10, on average, how painful were these headache (Where 0=no pain at all, and 10=pain which is as bad as it can be.). ☐

Add the total number of days from questions 1 to 5 (ignore A and B). ☐

- Number of severe headaches in the past mont ☐