**Headache Follow Up Visit Patient Questionnaire:**

How many headaches do you get each month? Please count ALL headaches.

How many headaches are likely migraine? Ie quite severe, light and noise sensitivity, hard to do your day to day life, nausea or vomiting?

How many days do you feel “crystal clear” with no headaches at all?

What do you take to treat your headaches when they come on?

How many times a week do you take these medications?

Have you been able to cut back on your rescue medications?

Please list ALL your other medications:

Have you seen an improvement in your headaches? How much ie %?

Since beginning treatment how would you describe the change (if any) in ACTIVITY LIMITATION, SYMPTOMS, EMOTIONS AND OVERALL QUALITY OF LIFE:

1. No change
2. Minimal change
3. Moderate change
4. Marked change

Have you had any side effects from treatment?

Have you had a change in your health since you were seen last? Any new medical conditions?

Female patients: Please remember that many migraine medications would be dangerous for the fetus if you were to become pregnant. Please always discuss any pregnancy plans with Dr. Graboski

Pregnant: yes no (Please circle)

Any other concerns or questions?

Office use:

Date Last injection:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Botox script faxed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_