Patient Name _____ **Date** _____

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

Since the last visit, are you: ☐ Better ☐ Worse ☐ The Same

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 _____

Reviewed with patient on _____

Provider signature_____

CONTINUE ON THE OTHER SIDE ➔

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 findthe best treatment for you.

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 headaches?
(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 month ☐