HEADACHE SURGERY INFORMATION PACKET

Inside this packet, you will find a brochure containing important information about several possible sites for nerve decompression surgery. Please read this information before you begin to fill out the paperwork. Each patient has a different combination of sites for migraine surgery and our team relies on the information you provide to make the best surgical decision for you, so please be specific when completing the paperwork in this packet.

Step 1: Fill out the Headache Questionnaire
Use the headache log to help you report the specific information about your headaches. You may even begin to see a pattern about your headaches that you did not realize before. Please use this form to provide additional information that you could not put on the headache log.

Step 2: Fill out the Headache Disability Questionnaire
Please be specific about any health issues you may have other than your headaches. Provide a list of the prescription and non-prescription medications you are taking. It does help if we know the dosages and how often you take the medications.

Step 3: Fill out the Functional Nose form
You and your family/friends can work together to help you complete this form. Pay attention to your body and daily functions in order to best answer these questions. For example, you may not have noticed that you breathe through your mouth instead of your nose.

Once you have completed the paperwork, please fax/email/mail the information to our office:
Knoxville Plastic & Craniofacial Surgery
9239 Park West Blvd, Suite 202
Knoxville, TN 3723
Fax: 865-973-9500
Email: info@drjasonhall.com

*If a CT scan has been advised, please bring the disc with you to your appointment*
HEADACHE HISTORY FORM

Patient Name: ___________________________________________ Date:_________________

• Who is your current treating physician? ___________________________________________________

• How many headaches do you experience per month on average? _______________________________

• How painful are is your average headache? (circle one number)

  1  2  3  4  5  6  7  8  9  10

  Mild  Severe

• How long do your headaches usually last? ____________________________________________________

• When do your headaches usually start? (circle one)

  Morning  Afternoon  Evening  Night

• Where are your headaches usually located? (circle all that apply)

  behind right eye  behind left eye  behind both eyes

  right temple     left temple      both temples

  above right eyebrow  above left eyebrow  above both eyebrows

  back of head on right  back of head on left  back of head both sides

• How old were you when your headaches started?

__________________________________________________________________
• How would you describe your headaches? (circle all that apply)
  throbbing/pounding  ache/pressure  like a tight band
  other (please describe): ________________________________________________________

• Do your headaches awaken you at night? (check one)
  never  occasionally  often

• Do any of the following occur before/during your headaches? (circle all that apply)
  nausea/vomiting  runny nose  bothered by light/noise
  blurry/double vision  flashing/colored lights  puffy/droopy eyelids
  other __________________________________________________________

• Do any of the following bring on your headaches or make them worse?
  stress  bright lights  weather changes
  loud noise(s)  heavy lifting  fatigue
  exercise
  other __________________________________________________________

• Do any of the following make your headaches better? (circle all that apply)
  rest  exercise  quiet/darkness
  pressure on head  massage  vomiting
  hot or cold compresses
  other __________________________________________________________
• Do you have any areas that are tender either before, during, or after a headache? (circle all that apply)
  above the eyebrows            the temple            in front or behind the ears
  the back of the neck          the bridge of the nose

• Does pressure or massage on the following areas reduce or eliminate the headache pain? (circle all that apply)
  above the eyebrows            the temple            in front of or behind the ears
  the back of the neck          the bridge of the nose

• If you are female, do your headaches change with any of the following?
  menstrual periods/pregnancy   birth control pills/ other hormones

• Have you ever had a head or a neck injury requiring medical treatment?
  no                                yes
  If yes, describe ________________________________________________________________

• Have you had your headaches evaluated by a neurologist?
  no                                yes
  If yes, by whom and when _________________________________________________________

• What was the diagnosis? (check all that apply)
  migraine            tension-type            cluster            occipital neuralgia
  other (specify) ________________________________________________________________
• List all past tests you had for your headaches:

_________________________________________________________________

_________________________________________________________________

• List all past headache treatment(s) and medications:

_________________________________________________________________

_________________________________________________________________

• List all current headache medications:

_________________________________________________________________

_________________________________________________________________

• To what extent do your headaches affect your quality of life? (check one)
  extremely              moderately            very little            none at all

• What activities in life have you given up because of your headaches? ________________________________

________________________________________________________________________
The Migraine Disability Assessment Test

The MIDAS (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS
Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have 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?

_______ 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.)

_______ 3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) 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 3 where you did not do household work.)

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

_______ Total (Questions 1-5)

_______ A. On how many days in the last 3 months did you have a headache? (If a 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 as bad as it can be.)

Scoring: After you have filled out this questionnaire, add the total number of days from questions 1-5 (ignore A and B)

<table>
<thead>
<tr>
<th>MIDAS Grade</th>
<th>Definition</th>
<th>MIDAS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Little or no disability</td>
<td>0-5</td>
</tr>
<tr>
<td>II</td>
<td>Mild disability</td>
<td>6-10</td>
</tr>
<tr>
<td>III</td>
<td>Moderate disability</td>
<td>11-20</td>
</tr>
<tr>
<td>IV</td>
<td>Severe disability</td>
<td>21+</td>
</tr>
</tbody>
</table>

Please give the completed form to your clinician.

This survey was developed by Richard B. Lipton, MD, Professor of Neurology, Albert Einstein College of Medicine, New York, NY, and Walter F. Stewart, MPH, PhD, Associate Professor of Epidemiology, Johns Hopkins University, Baltimore, MD.