

**MIGRAINE QUESTIONNAIRE**  
**(Complete all Questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated/relationship to applicant: \_\_\_\_\_

1. Date of diagnosis or first symptoms: \_\_\_\_\_

2. Frequency of headaches:  
\_\_\_\_\_ # per week  
\_\_\_\_\_ # per month

3. Are headaches mild, moderate or severe? \_\_\_\_\_

Date of last headache?: \_\_\_\_\_

Name and address of treating physician: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Any work loss or restricted activities? \_\_\_ Yes \_\_\_ No

If yes, give details: \_\_\_\_\_

5. Are you taking medication for this condition? \_\_ Yes \_\_ No

**Name of Medication:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_ **Frequency (ie., daily, as needed)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. How often do you see the doctor for this condition? \_\_\_\_\_

7. Results and dates of any special test/studies:

**Dates**

**Name of test/study & results**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Are the headaches caused by eye strain, sinus infection, hypertension, brain tumor, aneurysm, trauma, acute febrile illness or temporal arteritis? \_\_\_ Yes \_\_\_ No

If yes, provide details: \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand that the insurer will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated ( or parent / guardian if under 18)

\_\_\_\_\_  
Date