



Dear Patient:

Thank you for choosing the Dent Neurologic Institute, Western New York's premier Neurologic and Diagnostic Center.

Patients are required to arrive 30 minutes prior to their appointment time for the initial consultation. This time will be used to complete the registration process. Thank you for your understanding!

In order to ensure a positive experience, please be prepared with the following items on the day of your visit. Failure to comply may result in our need to reschedule your visit.

- ★ **Documents:** You must complete all the enclosed documents prior to your appointment time. **COMPLETION OF YOUR MEDICAL INTAKE FORMS IS CRITICAL IN ORDER FOR OUR PHYSICIANS APPROPRIATELY TREAT AND DIAGNOSIS.** If your visit is related to a work or motor vehicle accident, you must complete the application forms in their entirety.
- ★ **Payment:** If you have a co-pay or high deductible plan, you must bring payment with you; if you have a high deductible plan \$200 is required at the time of service; any remaining responsibility will be billed to you.
- ★ **Insurance Card:** You must provide us with your insurance card.
- ★ **Identification:** You must provide us with photo ID or two other forms of identification.
- ★ **Diagnostic Results:** Test results, diagnostic reports, films and CDs from all physicians treating you are **REQUIRED** at visit

Be sure to visit our website at www.dentinstitute.com for insurances we accept and access to your on-line secured medical record.

Once again, thank you for choosing the Dent Neurologic Institute. If you have any questions, please feel free to call our Center at 716-250-2000.

Advance Notice is Required for all Cancellations

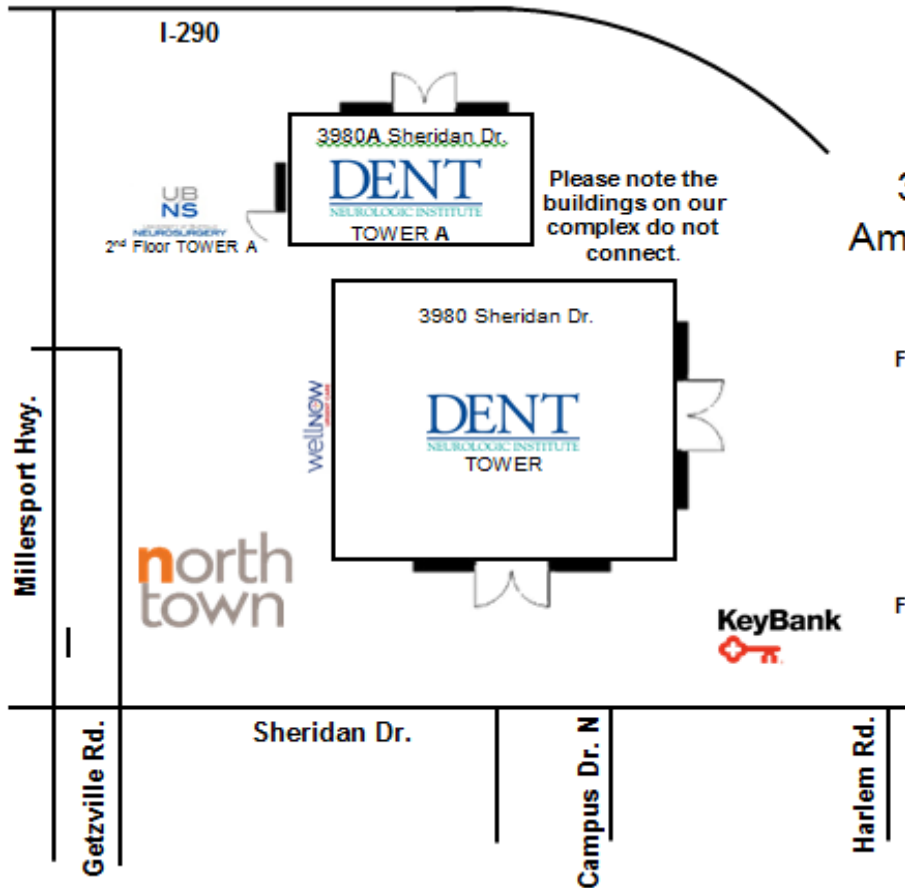
If you fail to cancel an appointment at least one business day prior; or you do not show for your scheduled appointment, you will be assessed a non-timely cancellation fee.

DENT

NEUROLOGIC INSTITUTE

Amherst Location

3980 Sheridan Drive
Amherst, New York 14226



DRIVING DIRECTIONS:

FROM NIAGARA FALLS/NORTHTOWN S

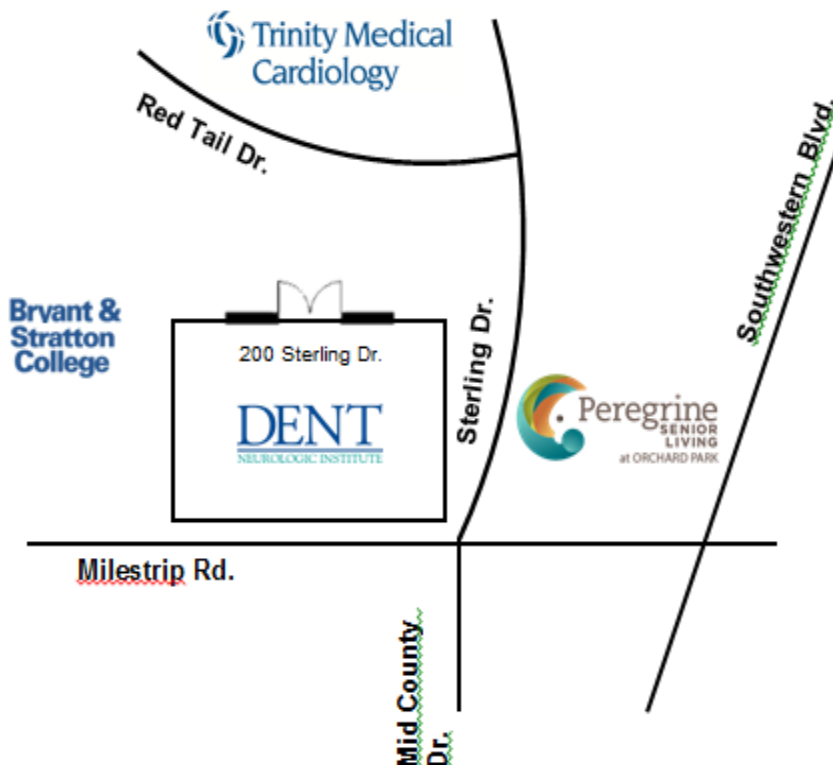
- Robert Moses Parkway South
- I-190 South
- I-290 East
- (Youngman Exp/Exit 16 to wards I-90)
- Exit Harlem Road (Exit 6)
- Right onto Harlem Road
- Left onto Sheridan Drive
- Right at light into Dent Tower

FROM SOUTHTOWNS

- I-190 East
- Merge into I-290
- (Youngman Exp/Exit 50)
- Exit Sheridan Drive (Exit 6)
- Left onto Sheridan Drive
- Right at light into Dent Tower

Orchard Park Location

200 Sterling Drive
Orchard Park, NY 14127



DRIVING DIRECTIONS:

FROM SOUTHTOWNS

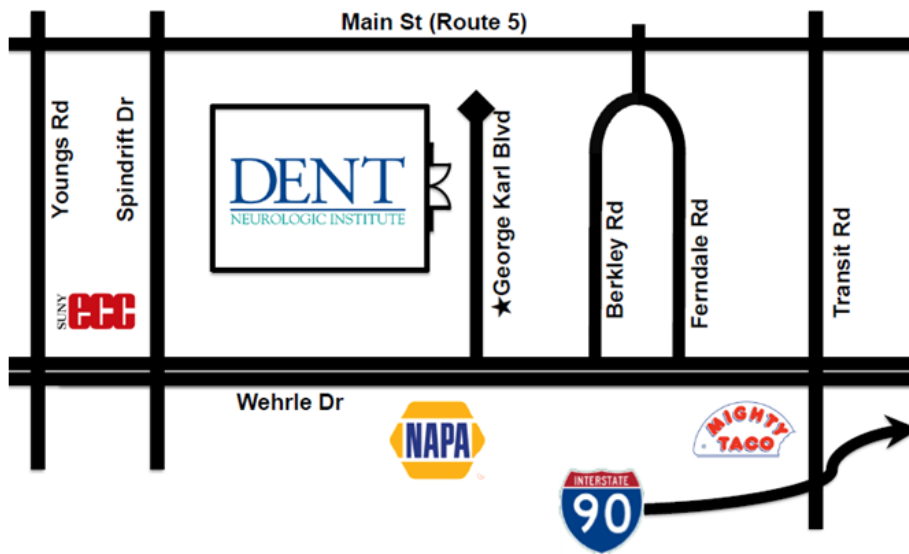
- Route 219 N to Milestrip Road East
- (1st Exit onto Milestrip Road)
- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM BUFFALO

- Thruway (90) West to Route 219
- Exit Milestrip Road East
- (2nd Exit onto Milestrip Road)
- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM PENNSYLVANIA

- Thruway (90) East to Exit 56
- Left onto Milestrip Road
- Left onto Sterling Drive
- Left on Red Tail
- Left into parking lot



Buffalo Location
40 George Karl Boulevard
Buffalo, NY 14221
Suite 120

From Niagara Falls

- I-190 South toward Buffalo
- Exit 16 for I-290 East toward Rochester/ Tonawanda
- Take ramp left for Thruway I-90 East toward Albany (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

From Buffalo

- Route 33 East toward Airport
- Take ramp right for Thruway I-90 East toward Albany (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

From Southtowns

- Route 219 North toward Buffalo
- Take ramp right for Thruway I-90 East toward Buffalo (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

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DENT NEUROLOGIC INSTITUTE

REGISTRATION FORM

Today's Date:			
PATIENT INFORMATION			
Last Name:		Middle:	First Name:
<input type="checkbox"/> Mr. / <input type="checkbox"/> Mrs. / <input type="checkbox"/> Miss / <input type="checkbox"/> Ms.		Marital Status (Check one):	<input type="checkbox"/> Single / <input type="checkbox"/> Married / <input type="checkbox"/> Divorced <input type="checkbox"/> Separated / <input type="checkbox"/> Widowed
Former Name:		Preferred Name:	
Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	E-mail Address:	
Home Phone: ()		Cell Phone: ()	
Street Address or P.O. Box:			
City:	State:	Zip Code:	Social Security Number:
Primary Physician:		Referring Physician:	
Race:	Ethnicity:	Language:	
Pharmacy Name:	Pharmacy Address:	Pharmacy Phone:	
CONTACT PERSON IN CASE OF EMERGENCY			
Name:		Relationship:	
Home Phone: ()		Cell Phone: ()	
SEXUAL ORIENTATION / GENDER IDENTITY			
Sexual Orientation (Check one):	<input type="checkbox"/> Lesbian, gay or homosexual / <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual / <input type="checkbox"/> Do not know / <input type="checkbox"/> Choose not to disclose		
	Something else, please describe:		
Gender Identity (Check one):	<input type="checkbox"/> Male / <input type="checkbox"/> Female / <input type="checkbox"/> Female-to-Male (FTM), Transgender Male, Trans Man <input type="checkbox"/> Male-to-Female (MTF), Transgender Female, Trans Woman <input type="checkbox"/> Genderqueer, neither exclusively male nor female <input type="checkbox"/> Choose not to disclose		
	Additional gender category or other, please specify:		

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INSURANCE INFORMATION

You will need to give your insurance card to the receptionist					
Last Name:		Middle:		First Name:	
Person Responsible for Bill (if not self):		Address (if different):		Home Phone: ()	
				Cell Phone: ()	
Birth Date: / /		Occupation:			
Responsible Party's Employer:		Employer Address:		Employer Phone: ()	
PRIMARY INSURANCE		Insurance Plan:			
Policy No:			Group No:		
Subscriber's Name (if not self):		Subscriber's SSN:			Co-pay Amount:
		Subscribers DOB: / /			
Patient's Relationship to Subscriber (Check one):		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
SECONDARY INSURANCE		Insurance Plan:			
Policy No:			Group No:		
Subscriber's Name (if not self):		Subscriber's SSN:			
		Subscribers DOB: / /			
Patient's Relationship to Subscriber (Check one):		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

**IF YOUR APPOINTMENT IS THE RESULT OF AN ACCIDENT OR INJURY,
YOU MUST COMPLETE THE ENCLOSED NO-FAULT OR WORKERS COMP FORM**

PLEASE READ

Important Insurance Plan Information

Before being seen, please review the following insurance participation information. Deductibles, co-insurances and co-pays are due at time of service. Estimated cost of an office visit ranges from \$75 - \$200; estimates for office procedures will be provided separately. If you have any questions or would like to receive an estimate for services, please call our Business Office at 250-2010.

DENT Participates with:

- Blue Cross Blue Shield (including Align programs)
- Empire
- Fidelis (**Not Accepting New Adult Patients**)
- Independent Health
- MagnaCare (including Health Republic)
- MVP (excluding Individual Exchange plans)
- Nova
- RMSCO (aka Lifetime Benefits Solutions)
- United Healthcare (Commercial and Medicare plans only)
- Univera
- Medicare and Medicare Railroad
- NYS Medicaid
- Wellcare (**Not Accepting New Patients**)
- Excellus - Blue Cross Plans (does not include Medicare Blue Choice Value/ Optimum or Monroe Medicaid plans)
- Martin's Point (varies by doctor)
- YourCare

DENT does NOT Participate with:

- Aetna (unless part of MultiPlan which varies by doctor)
- Cigna (unless part of MultiPlan which varies by doctor)
- Coventry/Health America
- Emblem Health/GHI -Imaging ONLY
- Excellus Plans (Premier Option)
- MVP (Individual Exchange plans)
- MultiPlan (varies by doctor)
- UPMC
- United Healthcare (Medicaid plans)
- Out of State Medicaid

In every case we will bill your insurance carrier on your behalf. Based on participation status you may have additional out-of-pocket expenses. We recommend you call your carrier directly to verify individual physician coverage.

Your insurance carrier may require you to utilize a specific laboratory testing facility. Please be sure to confirm this with the office staff.

Hospital Affiliations: Kaleida Health; Mercy Hospital of Buffalo

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DENT NEUROLOGIC INSTITUTE
WORKERS COMPENSATION
 SUPPLEMENTAL INFORMATION FORM

Today's Date:		Date of Birth:	
Patient Name:		Social Security No:	
Date of Injury:			
Employer Name:		Employer Address:	
Employer Phone Number: ()	Your Job Title:	Are you out of work due to this injury: <input type="checkbox"/> Yes <input type="checkbox"/> No	

COMPENSATION INSURANCE CARRIER INFORMATION

Insurance Carrier Name:		Insurance Carrier Address:	
Carrier Claim Number:		WCB Case Number:	
Name of Case Manager:		Phone: ()	
		Fax: ()	
Briefly Describe the Injury you Sustained:			
Briefly Describe how Injury Occurred:			

ATTORNEY INFORMATION

Attorney Name:		Attorney Address:	
Phone: ()		Fax: ()	

Please bring all Insurance Carrier and Workers Compensation Board information with you to your appointment. We may need to reschedule your appointment should you fail to include critical information concerning your Carrier.

DENT NEUROLOGIC INSTITUTE

NO-FAULT

SUPPLEMENTAL INFORMATION FORM

Patient Name:		Date of Birth:
		Social Security No:
Date of Accident:	Are You Currently Out of Work as a Result of this Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Injury Sustained:		
INSURANCE CARRIER INFORMATION		
Insurance Carrier Name:		Insurance Carrier Address:
Name of Adjuster:	Claim Number:	
Phone: ()	Fax: ()	
ACCIDENT DETAILS		
Location of Accident:		
Briefly Describe how the Accident Occurred:		
Were you a: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian		
If Driver or Passenger, were you: <input type="checkbox"/> Belted <input type="checkbox"/> Not-Belted		
Have you Filed a Claim with your Carrier: <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you Completed and Returned your No-Fault Application: <input type="checkbox"/> Yes <input type="checkbox"/> No
ATTORNEY INFORMATION		
Attorney Name:		Attorney Address:
Phone: ()	Fax: ()	
Signature:		Date:
FOR OFFICE USE ONLY		
PROVIDER: DENT NEUROLOGIC GROUP PO Box 8000 Dept 057 Buffalo, NY 14267 Signature: _____		CLAIM# _____ DATE OF LOSS: _____ CARRIER: _____

DENT NEUROLOGIC NEW PATIENT HISTORY FORM

Today's Date _____

Name: _____

DOB: _____

Age: _____

1. Please describe the problem that you would like addressed, e.g., what it consists of, how and when it started, what worsens and relieves it.

2a. Who is your **primary physician with address** (if known)?

2b. What physicians have you seen for this problem?

3. List all illnesses and/or hospitalizations/surgeries you have had during your life:

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

4. List the name and dose for each prescription and over-the-counter medication you are currently taking:

Drug:	Dose:
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

5. Any drug allergy?

<u>Drug</u>	<u>Reaction</u>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

6. What has been done for your problem? Medications? Physical therapy? Surgery? Other?

<u>Treatment</u>	<u>Date</u>	<u>Results</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Other problems? Please **circle** the ones that apply to you:

Neurologic

Headache, change in taste, smell or hearing, slurred speech, difficulty swallowing, dizziness, weakness, numbness, loss of consciousness, fainting, seizure, unsteadiness, falls, tremor, confusion, memory loss, head trauma, sleep problem, stroke/TIA (mini-stroke)

Constitutional

Fever, chills, fatigue, weight gain or loss, HIV/AIDS

Eyes

Blurry vision, double vision, decreased vision, cataract, glaucoma

Ears, Nose, Mouth, Throat

Hearing loss, ringing in the ears, earache, hoarseness, vertigo (spinning)

Cardiovascular

Chest pain, palpitations, leg edema, high blood pressure, heart attack, coronary artery disease/surgery, shortness of breath when lying down or on exertion, heart failure.

Respiratory

Cough, emphysema, asthma.

Gastro-Intestinal

Nausea, vomiting, heartburn, ulcers, abdominal pain, diarrhea, constipation, hepatitis

Genito-Urinary

Urinary incontinence/frequency/urge, sexual dysfunction, kidney problems

Skin

Rash or other skin abnormality

Musculoskeletal

Joint pain/swelling/stiffness, neck/lower back pain, muscle aches

Psychiatric

Depression, anxiety, other psychiatric problems

Print Name: _____

Continued from # 7

Endocrine

Diabetes, thyroid problems, hormonal problems

Hematologic

Anemia, easily bruises, bleeding disorder.

Allergy

Itching, rash, swollen lips/tongue.

Have you ever had cancer? ___ No ___ Yes, describe _____

8. Have you had any of the following tests?

<u>Test</u>	<u>Date</u>	<u>Where</u>
MRI	_____	_____
CT	_____	_____
Carotid Doppler	_____	_____
EMG	_____	_____
EEG	_____	_____
SPECT/PET	_____	_____
Other (myelogram, angiogram, biopsy, spinal tap):		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Do you use tobacco? ___ No ___ Yes, pack per day ____, # of years ____ Quit date _____

Do you use alcohol? ___ No ___ Yes, amount _____

Who lives with you at home? _____

Describe your work: _____

Disability? _____ No _____ Yes, since _____

10. Have you fallen in the past 12 months? ___ No ___ Yes

Do you feel unsteady when standing or walking? ___ No ___ Yes

Print Name: _____

11. Tell us about your family's health:

Mother: _____

Father: _____

Brother #1: _____ Sister #1: _____

Brother #2: _____ Sister #2: _____

Brother #3: _____ Sister #3: _____

Brother #4: _____ Sister #4: _____

12. What do you hope to achieve with your doctor?

13. Emergency contact:

Name: _____ Relationship: _____

Phone: _____ Mobile Phone: _____

Print Name

Signature

Date

Tell Us How We're Doing!
Visit Our Website at www.dentinstitute.com and take our online survey

For office use only:


BP _____ Pulse _____ Resp. _____ Wt. _____ Ht. _____

Headache History & Profile Questionnaire

Name: _____

DOB: _____

Date: _____

1. On what part of the head does the headache start? Circle all that apply and use the diagram to shade areas of pain:										
R-Side	L-Side	Either Side	Both Sides							
Back	Top	Temples	Behind/Around eye							
Forehead	Face	Neck	Other _____							
										
2. How long ago did the current headaches start? ___ Weeks ___ Months ___ Years										
3. How old were you when any headache started? ___										
4. How long does the headache usually last: ___ Minutes ___ Hours ___ Days ___ Constant										
5. How often does the headache occur? ___x/Day ___x/Week ___x/Mo ___x/Year ___ Constant										
6. Is the headache getting: <input type="checkbox"/> more severe <input type="checkbox"/> more frequent <input type="checkbox"/> both										
7. After the headache starts does it: <input type="checkbox"/> stay in one place <input type="checkbox"/> move around Explain: _____										
8. How would you describe the pain? <input type="checkbox"/> throbbing/pulsating <input type="checkbox"/> pressing/squeezing <input type="checkbox"/> stabbing <input type="checkbox"/> sharp <input type="checkbox"/> dull/nagging <input type="checkbox"/> other: _____										
9. On a scale of 1 to 10, describe the degree of pain when:										
Your headache starts:	1	2	3	4	5	6	7	8	9	10
With most of your headaches:	1	2	3	4	5	6	7	8	9	10
With your worst headache:	1	2	3	4	5	6	7	8	9	10
10. Do your headaches prevent normal activities such as work, school, etc? <input type="checkbox"/> yes <input type="checkbox"/> no										
12. Has productivity at work or school been affected by your headaches? <input type="checkbox"/> yes <input type="checkbox"/> no										
13. In the last month has your headaches caused you to miss leisure activities/work/school? <input type="checkbox"/> yes <input type="checkbox"/> no										
14. In the last 6-months, has your headaches caused you to miss leisure activities/work/school? <input type="checkbox"/> yes <input type="checkbox"/> no										
15. Do any blood relatives have severe headaches: <input type="checkbox"/> yes <input type="checkbox"/> no If yes, who & diagnosis: _____										
16. Do any have history of head or neck injury? <input type="checkbox"/> yes <input type="checkbox"/> no										
17. If yes, did this involve a loss of consciousness? <input type="checkbox"/> yes <input type="checkbox"/> no										
18. Which of the following makes the headache better (circle all that apply):										
Rest	Activity	Darkness	Quiet	Cold Compresses	Hot Compress	Scalp/temple pressure				
19. Do you exercise regularly? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, how often and what: _____										
20. Do you frequently skip meals? <input type="checkbox"/> yes <input type="checkbox"/> no										
21. How much caffeine do you eat/drink in a day? (i.e. coffee, tea, soda, chocolate) _____										
22. Social History: Cigarettes (#day/#yrs) ___/___ Coffee (cups/day) ___/___										
23. Do you have any problems sleeping? <input type="checkbox"/> yes <input type="checkbox"/> no										
24. Does the headache awaken you from sleep? <input type="checkbox"/> yes <input type="checkbox"/> no										
25. Do you awake feeling rested? <input type="checkbox"/> yes <input type="checkbox"/> no										
26. Are you or have you been depressed or anxious? <input type="checkbox"/> yes <input type="checkbox"/> no										

Associated Headache Symptoms:

Are any of the following symptoms associated with the headache? Please mark: (B) Before (X) During (A) After			
<p>FACE AND SCALP:</p> <p><input type="checkbox"/> Spots before eyes R/L</p> <p><input type="checkbox"/> Blindness R/L</p> <p><input type="checkbox"/> Blurring R/L</p> <p><input type="checkbox"/> Eyelid Droop R/L</p> <p><input type="checkbox"/> Tearing R/L</p> <p><input type="checkbox"/> Double Vision R/L</p> <p><input type="checkbox"/> Eye Redness R/L</p> <p><input type="checkbox"/> Eyes Puffy R/L</p> <p><input type="checkbox"/> See only half objects R/L</p> <p><input type="checkbox"/> Noise Sensitivity</p> <p><input type="checkbox"/> Odor Sensitivity</p> <p><input type="checkbox"/> Light Sensitivity</p> <p><input type="checkbox"/> Nose Discharge R/L</p> <p><input type="checkbox"/> Nose Blocked R/L</p> <p><input type="checkbox"/> Paleness</p> <p><input type="checkbox"/> Redness</p> <p><input type="checkbox"/> Sweating</p> <p><input type="checkbox"/> Tenderness</p> <p><input type="checkbox"/> Pain on chewing</p> <p><input type="checkbox"/> Puffiness</p> <p><input type="checkbox"/> Decreased jaw opening</p> <p>PLEASE MARK IF YOU EXPERIENCE: (W) Weakness (N) Numbness (B) Both</p> <p><input type="checkbox"/> Face R/L</p> <p><input type="checkbox"/> Arms R/L</p> <p><input type="checkbox"/> Legs R/L</p> <p><input type="checkbox"/> Arm and Leg R/L</p> <p><input type="checkbox"/> Numbness around Lips</p>	<p>GENERAL:</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Stomach Cramps</p> <p><input type="checkbox"/> Hunger</p> <p><input type="checkbox"/> Loss of Appetite</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Irritability</p> <p><input type="checkbox"/> Difficulty concentrating</p> <p><input type="checkbox"/> Difficulty talking or finding words</p> <p><input type="checkbox"/> Difficulty understanding</p> <p><input type="checkbox"/> Fainting or feel like fainting</p> <p><input type="checkbox"/> Slurred speech</p> <p><input type="checkbox"/> Dizziness</p> <p>NECK:</p> <p><input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> Tenderness</p> <p>HANDS AND/OR FEET:</p> <p><input type="checkbox"/> Cold</p> <p><input type="checkbox"/> Pale</p> <p><input type="checkbox"/> Sweaty</p> <p><input type="checkbox"/> Mottled</p>		
Indicate if any of the following factors have (+) Brought on (trigger) or (++) Worsened your headache:			
<p><input type="checkbox"/> Sleep too much or little</p> <p><input type="checkbox"/> Emotional stress</p> <p><input type="checkbox"/> Depression - anxiety</p> <p><input type="checkbox"/> Physical Activity</p> <p><input type="checkbox"/> Erect Position</p> <p><input type="checkbox"/> Bending Over</p>	<p><input type="checkbox"/> Missed Meal</p> <p><input type="checkbox"/> Change in Weather</p> <p><input type="checkbox"/> Seasons</p> <p><input type="checkbox"/> Processed Meats</p> <p><input type="checkbox"/> Chocolate</p> <p><input type="checkbox"/> Citrus Fruits</p>	<p><input type="checkbox"/> Cheese</p> <p><input type="checkbox"/> MSG</p> <p><input type="checkbox"/> Other foods (list)</p> <p><input type="checkbox"/> Straining/Coughing</p> <p><input type="checkbox"/> Menstrual Periods</p> <p><input type="checkbox"/> Oral Contraceptives</p>	<p><input type="checkbox"/> Medications (list)</p> <p><input type="checkbox"/> Menstrual Periods</p> <p><input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> Menopause</p> <p><input type="checkbox"/> Oral Contraceptives</p>

Patient Name: _____

Chronic Migraine Screener

What is Chronic Migraine?

Chronic Migraine is a condition defined as 15 or more headache days a month with each headache lasting 4 hours or more per day. At least half of the headaches should be migraine.

How to use this screener:

The following questions can help you and your physician understand your condition and help determine if you have Chronic Migraine. Being thorough about your headaches/migraines will help your physician determine how much of your headaches affect your daily life and help get you to a more accurate diagnosis and find treatment options that are right for you.

Personal Information

Name: _____

Date of Birth: _____

Important information before you get started

What are headache days?

It is important to understand the number of days you had *headaches* (including migraines) rather than the number of *attacks*.

- For example, you have a headache that starts on Monday and does not go away until Wednesday; it may be one attack, but that is considered 3 *headache days*

Remember to provide your doctor with an accurate number of **ALL of the days you experience pain of any kind.**

Are migraine days the same as headache days?

Some of your headaches may be a type of headache known as *migraine*. If you experience any combination of the following symptoms, your headache may be a migraine:

- Constant, throbbing pain felt on one side of the head (but can be on both sides)
- Sensitivity to light and sound
- Nausea and/or vomiting
- Headaches that get worse with movement (you may want to lay down)

Whether your headache is a migraine or not, it still counts as a *headache day*.

What if the headache gets better or goes away after I take medication?

You should also count days that you treated/resolved your headache/migraine with either an over-the-counter medication like ibuprofen or prescription medication like sumatriptan. These days are still considered as days *with* headache

Please complete this to see if you may have Chronic Migraines

1(a) How many days in the past month did you spend with a headache/migraine? (Include ALL days with any headache pain of any kind, even those you didn't feel you needed to take any medication for or only took an over-the-counter medication) _____ day(s)

1(b) How many days in the past month did you spend without ANY headache pain of any kind (headache-free days)? _____ day(s)

1(c) Subtract line B from 31 and enter the number: _____ day(s)

Regarding question 1 (a) or (c) was the answer 15 or more?

Yes or No

2 Did any of your headaches/migraines last more than 4 hours, if you did not treat them?

Yes or No

3 Have you ever been diagnosed as having chronic headaches (including tension-type or chronic sinus headaches)?

Yes or No

4 Have you ever been diagnosed as having migraines?

Yes or No

5 Do your headaches/migraines impact your daily life?

Yes or No

Rate the impact of your headaches/migraines on your daily life:

1 2 3 4 5 6 7 8 9 10
Mild Severe

How many days in the past month have your headaches/migraines severely affected your daily life?

_____ day(s)

6 In the past month, did you take anything to treat your headaches/migraines?

Yes or No

If "yes," how many days in the past month did you take something to treat your headaches/migraines (including over-the-counter drugs, prescription medication and/or vitamins/herbal remedies)?

_____ day(s)

Please list what you have taken:

Check here if you answered "Yes" to both questions 1 and 2 and at least one of the other questions.

Patient Name: _____

Patient Name: _____ D.O.B: _____ Date: _____



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Adult MIDAS (18 years of age and older)

The MIDAS (migraine disability assessment) questionnaire was put together to help you measure the impact your headaches have on your life *over the last 3 months* and to communicate this more effectively. The best way to this is by counting the numbers of days of your life which are affected by Headaches.

INSTRUCTIONS • Please answers the following questions about *ALL your headaches you have had over the last 3 months*. Select your answer in the box next to each question. If a single headache affects more than one area of your life (e.g., work and family life) it is counted more than once. Select zero if you did not have the activity in the last 3 months. There are no “right” or “wrong” answers so please put down your best guess.

For questions 1 and 2, **work or school** means paid work or education if you are a student at school or college. For Questions 3 and 4, **household work** means activities such as housework, home repairs and maintenance, shopping as well as caring for children and relatives.

1. On how many days in the last 3 months did you miss work or school because 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 because of your headaches?

4. How many days in the last three 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.)

Patient Name: _____

D.O.B: _____

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

Enter the total number of days you entered in questions 1-5. This is your MIDAS level of disability.

Total

0 to 5 - MIDAS Grade I, *Little or no disability*

6 to 10 - MIDAS Grade II, *Mild disability*

11 to 20 - MIDAS Grade III, *Moderate disability*

21+ - MIDAS Grade IV, *Severe disability*

That Your Physician will need to know about your headache:

- 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.)