CHRONIC MIGRAINE EVALUATION

In this simple test, fill out how many days you experienced the following IN THE PAST MONTH. If it totals more than 15 days, you may have a chronic migraine. Knowing whether you have chronic migraines may help you find the treatment you need... and will help you to know that you are not alone.

<table>
<thead>
<tr>
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<th>Work or School</th>
<th>Housework, Home Repairs, Shopping, Caring for Children</th>
<th>Family, Social or Leisure Activities</th>
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</thead>
<tbody>
<tr>
<td>How many days did you miss these activities completely, because of your headaches?</td>
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<td>How many days was your ability to contribute to these activities reduced by half or more? (Not including the days listed above.)</td>
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</table>

**SUB-TOTAL**

**GRAND TOTAL**

**Scoring:**
- 0-5 You have minimal or infrequent disability from migraines.
- 6-10 This number indicates a moderate medical need. You may require a moderate therapy, such as prescription medication.
- 11-20 This number indicates a high medical need which may require acute therapy, such as medication, injections, and/or a medical procedure.

**ADDITIONAL QUESTIONS:**
- On how many days in the last three months did you have a headache? __________
- On a scale of 0 (no pain) to 10 (worst pain), on average how painful were these headaches? __________

Please give the completed form to your clinician.

This assessment was adapted from the MIDAS survey created 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.