MIGRAINE SPECIFIC QUALITY OF LIFE QUESTIONNAIRE

PATIENT NAME: _____

PATIENT INSTRUCTIONS:

Please fill out this questionnaire. It will help us understand the effects of migraine headache on your daily activities. The questionnaire has been designed so that it can be completed quickly and easily. Please check only one answer for each question. You should answer every question.

Thank you for your time.

While answering the following questions,
please think about **all migraine attacks** you may have had in the **past 4 weeks**

PLEASE SELECT ONLY ONE RESPONSE TO THESE QUESTIONS:

1. In the **past 4 weeks**, how often have migraines **interfered** with how well you dealt with family, friends and others who are close to you?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time

2. In the **past 4 weeks**, how often have migraines **interfered** with your leisure time activities, such as reading or exercising?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time

3. In the **past 4 weeks**, how often have you had **difficulty** in performing work or daily activities because of migraine symptoms?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time

4. In the **past 4 weeks**, how often did migraines **keep you** from getting as much done at work or at home?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time

5. In the **past 4 weeks**, how often did migraines **limit** your ability to concentrate on work or daily activities?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time

6. In the **past 4 weeks**, how often have migraines **left you too tired** to do work or daily activities?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time

7. In the **past 4 weeks**, how often have migraines **limited** the number of days you have felt energetic?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time

8. In the **past 4 weeks**, how often have you had to **cancel** work or daily activities because you had a migraine?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time

9. In the **past 4 weeks**, how often did you **need help** in handling routine tasks. such as every day household chores, doing necessary business, shopping, or caring for others, when you had a migraine?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time

10. In the **past 4 weeks**, how often did you have to **stop** work or daily activities to deal with migraine symptoms?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time

11. In the **past 4 weeks**, how often were you **not able to go** to social activities such as parties or dinner with friends because you had a migraine?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time

12. In the **past 4 weeks**, how often have you **felt** fed up or frustrated because of your migraines?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time

13. In the past 4 weeks, how often have you felt like you were a burden on others because of your migraines?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time

14. In the **past 4 weeks**, how often have you been **afraid** of letting others down because of your migraines?

(Select one response)

- ☐ None of the time
- ☐ A little bit of the time
- ☐ Some of the time
- ☐ A good bit of the time
- ☐ Most of the time
- ☐ All of the time