NAME: _____ DOB: _____

DATE: _____

THE MIGRAINE DISABILITY ASSESSMENT TEST (MIDAS)

The MIDAS questionnaire was put together to help you measure the impact your headaches have on our life. The information on this questionnaire is also helpful for you Provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS: Numerical Answers Only Please-Thank you.

Please answer the following questions about **ALL** of the headaches you have over the last 3 months (90 days or 12 weeks). Place your numerical answer in the box next to each question. Select zero if you do not have the activity in the last 3 months or if it does not apply to you.

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

_____ 2. How many days in the last 3 months was your productivity difficult at work or school being reduced by half or more because of your headaches? (Do not include days you counted in #1.)

_____ 3. On how many days in the last 3 months were you completely unable to perform household duties because of your headaches? (Ext. Housework, home repairs, shopping, caring for relatives).

_____ 4. How many days in the last 3 months was your ability to perform household duties reduced by half or more because of your headaches? (Do not include days you counted in question #3)

_____ 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)

WHAT YOUR PROVIDER WILL NEED TO KNOW ABOUT YOUR HEADACHES:

_____ A. On how many days in the last 3 months did you have a headache? (If headache lasted more than 1 day, count each day).

_____ B. On a scale of 0-10, on AVERAGE how painful were these headaches? (0= No Pain, 10=Pain As Bad As It Can Be).

INSTRUCTIONS: Please circle the percentage (%) of improvement you have had.

NA=Not Applicable

1. Since your last visit, what has been the percentage (%) of improvement of how OFTEN you get a headache?

0 • 10 • 20 • 30 • 40 • 50 • 60 • 70 • 80 • 90 • 100 • NA

2. Since your last visit, what has been the percentage (%) of reduction of how severe your pain has been with your headaches?

0 • 10 • 20 • 30 • 40 • 50 • 60 • 70 • 80 • 90 • 100 • NA

3. Overall, since starting treatment what has been the percentage (%) of improvement you have experienced?

0 • 10 • 20 • 30 • 40 • 50 • 60 • 70 • 80 • 90 • 100 • NA

"PLEASE RETURN THIS FORM TO THE FRONT DESK FOR FASTER SERVICE"