



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

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