# Brad Gandolfi M.D.

# Preliminary Migraine Patient Questionnaire

In an effort to provide the most appropriate migraine treatment, we must carefully assess all new patients. This questionnaire is the first step in our migraine treatment process. Please complete the information below and return it to our office at your earliest convenience.

Name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Home Phone: ______________ Cell Phone: ______________

Email: ______________________________

How did you learn about the surgical treatment of migraine headaches?

| ***Please check "YES" or "NO" to the below questions:*** | YES | NO |
|---|---|---|
| Do you have migraine headaches that start from behind or around the eyes? | | |
| Do you get pain in the cheeks or ears? | | |
| Do you wake up in the morning with headache or are you awakened by headache? | | |
| Do you experience nasal congestion or runny nose before, during or after headache? | | |
| Does the weather change cause headache to be more severe or last longer? | | |
| Do you have chronic daily headache? | | |
| Do smells trigger or make your headache worse? | | |
| Do you get a headache when you fly in an airplane? | | |
| Do you get migraine during your menstrual cycle? | | |
| Are you currently being treated by a neurologist? | | |
| Have you had Botox® injections for your migraine headaches? | | |
| Do you have a history of health issues? (such as diabetes or high blood pressure) | | |
| If "Yes", please describe: | | |
| | | |

Are you currently being treated for migraines? If so, by whom?

Name:______________________________ Practice Affiliation: ______________________________

PATIENT NAME______________________________DATE_______
FUNCTIONAL NOSE INFORMATION SHEET

| ***Please check "YES" or "NO" to the below questions:*** | ***Yes*** | ***No*** |
|---|---|---|
| Do you have any difficulty breathing through your nose? | | |
| Do you experience sinus headaches? | | |
| Are you a mouth breather? | | |
| Do you experience sore throats and dry chapped lips in the morning as a result of mouth breathing? | | |
| Do you snore? | | |
| Do you find that it is harder to breathe through your nose when lying down? | | |
| Do you find it necessary to prop yourself up on more than one pillow? | | |
| Do you use any of the following? | | |
| Nasal irrigations or sprays? | | |
| Vaporizer/Humidifier? | | |
| Do you take over-the-counter nose sprays and decongestants? If yes, please list them: | | |
| Do you wake up at night due to difficulty breathing through your nose? | | |
| Do your breathing problems limit your participation inactivities such as running, sports, or other forms of exercise? | | |
| Do you find yourself tired during the day as a consequence of waking up at night due to breathing difficulty? | | |
| If yes, does this interfere with your daily function or job performance? | | |
| Have you seen a medical doctor for treatment of the breathing problem through your nose?<br>If yes: Doctor's name________________________________________<br>Address __________________________________________________<br>Treatment dates _____________________________________________<br>What treatment was advised?__________________________________<br>Did you benefit from the treatment? | | |

Please email your completed form to questions@drgandolfi.com or fax it to (201) 261-7515.
*This form was adapted with permission from Bahman Guyuron www.drbahmanguyuron.com
We look forward to meeting you!