Headache Therapies Questionnaire

Therapies attempted – prior to Botox treatment

Patient Name:_____ **Patient DOB:**_____

Physician:_____ **Today's Date:**_____

1. **Number of migraine headache days per month on average for the last 3 months:** _____

2. **Length of migraine (hours) per day on average for the last 3 months:** _____

3. **Prior/current preventative medications:**

	Yes	No
Gabapentin		
Propranolol/beta blockers		
Topiramate		
Tricyclic antidepressants		
Valproic acid (Depakote)		
Verapamil		
SSRIs		

4. **Prior/current acute use medications**

	Yes	No
Fioricet/fiorinal		
Midrin		
Narcotics		
NSAIDs		
Reglan		
Tramadol		
Triptans		
Tylenol		

5. **If the patient has NOT been tried on one of the following, are they medically contraindicated in the patient?**

	Yes	No
Beta blockers		
Serotonin receptor agonists (triptans)		
Topiramate		
Divalproex		
NSAID		