Bahman Guyuron, 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 would you prefer to receive the packet of information and forms for the consult with Dr. Guyuron? (circle one) Email Regular mail

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:		

Please email your completed form to mvanness@guyuron.com or fax it to (440)461-4713.
Your Migraine packet will arrive in the mail soon. We look forward to meeting you!