

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

MSQ

PATIENT INSTRUCTIONS: These questions are designed to help us understand the effects of migraine headache on your daily activities. Please check only one answer for each question. **While answering the following questions, please think about all migraine attacks you may have had in the past 4 weeks.**

	None of the time	A little bit of the time	Some of the time	A good bit of the time	Most of the time	All of the time
1. How often have migraines <b>interfered</b> with how well you dealt with family, friends and others who are close to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How often have migraines <b>interfered</b> with your leisure time activities, such as reading or exercising?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How often have you had <b>difficulty</b> in performing work or daily activities because of migraine symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How often did migraines <b>keep you</b> from getting as much done at work or at home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How often did migraines <b>limit</b> your ability to concentrate on work or daily activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How often have migraines <b>left you too tired</b> to do work or daily activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How often have migraines <b>limited</b> the number of days you have felt energetic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. How often have you had to <b>cancel</b> work or daily activities because you had a migraine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. How often did you <b>need help</b> in handling routine tasks such as every day household chores, doing necessary business, shopping, or caring for others, when you had a migraine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. How often did you have to <b>stop</b> work or daily activities to deal with migraine symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. How often were you <b>not able to go</b> to social activities such as parties, dinner with friends, because you had a migraine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. How often have you <b>felt</b> fed up or frustrated because of your migraines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. How often have you <b>felt</b> like you were a burden on others because of your migraines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. How often have you been <b>afraid</b> of letting others down because of your migraines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>