IDENTIFYING CHRONIC MIGRAINE

Name_____

Date_____

Are you among the millions of Americans who don't know they have **Chronic Migraine**?[1-3] Complete this tool and bring it to your doctor to start an important conversation about your headaches.

ID-Chronic Migraine (ID-CM) is a screening tool created by a team of headache experts. It is designed to help your doctor see if you may have Chronic Migraine.

Instructions:

1. Answer all questions on pages 2 and 3.
2. Go to page 4 and tally your responses to bring to your doctor.
3. Fill out your medical history on page 4.
4. Use the ID-CM tool to talk to your doctor about Chronic Migraine and available treatment options.

Let's get started!

What was the FREQUENCY of your headaches?

When answering the next 2 questions, if you don't remember the exact number of headache days, please give the best answer you can. If a headache lasted more than 1 day, count each day.

1. **In the last 3 months (past 90 days), on how many days did you have a headache of any type?** Number of days: ○ > If you answered 45 days or more, check the "Frequency" box

2. **In the last month (past 30 days), on how many days did you have a headache of any type?** Number of days: ○ > If you answered 15 days or more, check the "Frequency" box

> FREQUENCY ☐

What were your SYMPTOMS when you had headaches in the last month **(past 30 days)**?

Describe the pain and other symptoms you have with your headaches. If you have more than 1 type of headache, **please answer for your most severe type.**

	A Never	B Rarely	C Less than half the time	D Half the time or more
3. How often were you unusually sensitive to light (eg, you felt more comfortable in a dark place)?	○	○	○	○
4. How often were you unusually sensitive to sound (eg, you felt more comfortable in a quiet place)?	○	○	○	○
5. How often was the pain moderate or severe?	○	○	○	○
6. How often did you feel nauseated or sick to your stomach?	○	○	○	○

> If you answered "C" or "D" to questions 3, 4, AND 5, check the "Symptoms" box

> If you answered "C" or "D" to both questions 5 AND 6, check the "Symptoms" box

SYMPTOMS ☐

What was your MEDICATION USE for headache in the last month **(past 30 days)**?

When answering the next 2 questions, only count medications you take as needed to relieve headache.

7. **How many days did you use over-the-counter medications to treat your headache attacks?** Number of days: ○ >

8. **How many days did you use prescription medications to treat your headache attacks?** Number of days: ○ >

> If you answered 10 days or more to either question, check the "Medication Use" box

MEDICATION USE ☐

How often did headache interfere with ACTIVITIES in the last month **(past 30 days)**?

9. **How many days did you miss work or school because of your headaches?** Number of days: ○ >

10. **How many days did you miss family, social, or leisure activities because of your headaches?** Number of days: ○ >

> If you answered 10 days or more to either question, check the "Activities" box

ACTIVITIES ☐

How often did headache affect MAKING PLANS in the last month **(past 30 days)**?

	A Never	B Rarely	C Less than half the time	D Half the time or more
11. How often did your headaches interfere with making plans?	○	○	○	○
12. How often did you worry about making plans because of your headaches?	○	○	○	○

> If you answered "D" to either question, check the "Making Plans" box

MAKING PLANS ☐

Continue answering questions on the next page.

Go to page 4 to tally your responses and fill out your medical history.

Tally your responses and then bring this information to your doctor. Your doctor is the only one who can diagnose Chronic Migraine. Chronic Migraine is a treatable medical condition defined by 15 headache days per month with each headache lasting 4 hours or more, including 8 or more days with migraine.[4]

Go back to page 2.

If you checked both of these boxes

☑ FREQUENCY
and
☑ SYMPTOMS

> **You may have Chronic Migraine**

or

Go back to page 3.

If you checked all 3 of these boxes

☑ MEDICATION USE
and
☑ ACTIVITIES
and
☑ MAKING PLANS

> **You may have Chronic Migraine**

Write down some important information to help talk to your doctor about your headaches

Name of your headache/ migraine acute and/or preventive medications (over-the-counter and prescription), both current and past*	How often you took it (per day & per month)	How much (eg, 25-mg pill)	How long you took it (eg, 3 months)	How it worked

How do headaches/migraines affect your daily life (work, school, activities, family, etc)?_____

*Please record medications you have taken as needed to relieve headache and those you have taken on a schedule to prevent headaches/migraines.

Questions to ask your doctor:

- Do I have Chronic Migraine?
- What treatments are available for Chronic Migraine?

Visit MyChronicMigraine.com to learn more about Chronic Migraine and to sign up for more information.

ALLERGAN

References: 1. Natoli JL, Manack A, Dean B, et al. Global prevalence of chronic migraine: a systematic review. *Cephalalgia*. 2010;30(5):599-609. **2.** Centers for Disease Control and Prevention. Census projections request. CDC WONDER website. http://wonder.cdc.gov/population-projections.html. Accessed October 22, 2014. **3.** Bigal ME, Serrano D, Reed M, Lipton RB. Chronic migraine in the population: burden, diagnosis, and satisfaction with treatment. *Neurology*. 2008;71(8):559-566. **4.** Lipton RB. Chronic migraine, classification, differential diagnosis, and epidemiology. *Headache*. 2011;51(suppl 2):77S-83S.