# MIGRAINE QUIZ

Print this form or download it to your mobile device to prepare for your next appointment with your healthcare provider.

1. **Do you have 4 or more migraine days per month?**
   - ☐ Yes ☐ No

2. **How many days are you impacted by migraine symptoms in an average month?_____**

3. **How long do your migraine attacks usually last?** _____ (hours) or _____ (days)

4. **Which of the following symptoms do you usually have with your migraine?**
   - ☐ Pulsing/throbbing headache
   - ☐ Light sensitivity
   - ☐ Nausea or vomiting
   - ☐ Changes to your vision
   - ☐ Temporary vision loss
   - ☐ Other symptoms:

5. **What medications do you take to treat your migraine? (Select all that apply.)**
   - ☐ Over-the-counter medications to treat migraine symptoms once they start
   - ☐ Prescription medications to treat migraine symptoms once they start
   - ☐ Prescription medications to help prevent migraine

6. **Do you still experience migraine headaches regularly?**
   - ☐ Yes ☐ No

Please speak to your doctor about how migraine impacts your day-to-day activities (eg, at work, school, home).

## READY TO LEARN MORE?

**Use this quiz or the Doctor Discussion Guide to help start the conversation with your doctor about migraine.**

These questions are not intended for use in the diagnosis or prevention of migraine or other conditions.



Lundbeck