

MIGRAINE QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Date of diagnosis or first symptoms: _____

2. Frequency of headaches: _____ # per week _____ # per month

3. Are headaches mild, moderate or severe? _____

Date of last headache? _____

Name and address of treating physician: _____

4. Any work loss or restricted activities? Yes _____ No _____

If yes, give details: _____

5. Are you taking medication for this condition? Yes _____ No _____

Name of Medication: _____ **Dosage:** _____ **Frequency (i.e., daily, as needed)**

6. How often do you see the doctor for this condition? _____

7. Results and dates of any special test/studies:

Dates	Name of test/study & results
_____	_____
_____	_____
_____	_____

8. Are the headaches caused by eyestrain, sinus infection, hypertension, brain tumor, aneurysm, trauma, acute febrile illness or temporal arteritis: Yes _____ No _____

If yes, provide details: _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date