MIGRAINE SPECIFIC QUALITY OF LIFE QUESTIONNAIRE
(VERSION 2.1)

PATIENT INSTRUCTIONS:

Please fill out this questionnaire. It will help us understand the effects of migraine headache on your daily activities.

The questionnaire has been designed so that it can be completed quickly and easily. Please check only one answer for each question. You should answer every question.

Thank you for your time.
While answering the following questions, please think about all migraine attacks you may have had in the past 4 weeks.

1. In the past 4 weeks, how often have migraines interfered with how well you dealt with family, friends and others who are close to you? (Select only one response.)

   1. None of the time
   2. A little bit of the time
   3. Some of the time
   4. A good bit of the time
   5. Most of the time
   6. All of the time

2. In the past 4 weeks, how often have migraines interfered with your leisure time activities, such as reading or exercising? (Select only one response.)

   1. None of the time
   2. A little bit of the time
   3. Some of the time
   4. A good bit of the time
   5. Most of the time
   6. All of the time

3. In the past 4 weeks, how often have you had difficulty in performing work or daily activities because of migraine symptoms? (Select only one response.)

   1. None of the time
   2. A little bit of the time
   3. Some of the time
   4. A good bit of the time
   5. Most of the time
   6. All of the time

4. In the past 4 weeks, how often did migraines keep you from getting as much done at work or at home? (Select only one response.)

1. None of the time
2. A little bit of the time
3. Some of the time
4. A good bit of the time
5. Most of the time
6. All of the time

5. In the past 4 weeks, how often did migraines limit your ability to concentrate on work or daily activities? (Select only one response.)

1. None of the time
2. A little bit of the time
3. Some of the time
4. A good bit of the time
5. Most of the time
6. All of the time

6. In the past 4 weeks, how often have migraines left you too tired to do work or daily activities? (Select only one response.)

1. None of the time
2. A little bit of the time
3. Some of the time
4. A good bit of the time
5. Most of the time
6. All of the time

7. In the past 4 weeks, how often have migraines limited the number of days you have felt energetic? (Select only one response.)

1. None of the time
2. A little bit of the time
3. Some of the time
4. A good bit of the time
5. Most of the time
6. All of the time

8. In the past 4 weeks, how often have you had to cancel work or daily activities because you had a migraine? (Select only one response.)

1. None of the time
2. A little bit of the time
3. Some of the time
4. A good bit of the time
5. Most of the time
6. All of the time

9. In the past 4 weeks, how often did you need help in handling routine tasks such as every day household chores, doing necessary business, shopping, or caring for others, when you had a migraine? (Select only one response.)

1. None of the time
2. A little bit of the time
3. Some of the time
4. A good bit of the time
5. Most of the time
6. All of the time

10. In the past 4 weeks, how often did you have to stop work or daily activities to deal with migraine symptoms? (Select only one response.)

1. None of the time  
2. A little bit of the time  
3. Some of the time  
4. A good bit of the time  
5. Most of the time  
6. All of the time

11. In the past 4 weeks, how often were you not able to go to social activities such as parties, dinner with friends, because you had a migraine? (Select only one response.)

1. None of the time  
2. A little bit of the time  
3. Some of the time  
4. A good bit of the time  
5. Most of the time  
6. All of the time

12. In the past 4 weeks, how often have you felt fed up or frustrated because of your migraines? (Select only one response.)

1. None of the time  
2. A little bit of the time  
3. Some of the time  
4. A good bit of the time  
5. Most of the time  
6. All of the time
13. In the past 4 weeks, how often have you felt like you were a burden on others because of your migraines? (Select only one response.)

1 □ None of the time  
2 □ A little bit of the time  
3 □ Some of the time  
4 □ A good bit of the time  
5 □ Most of the time  
6 □ All of the time

14. In the past 4 weeks, how often have you been afraid of letting others down because of your migraines? (Select only one response.)

1 □ None of the time  
2 □ A little bit of the time  
3 □ Some of the time  
4 □ A good bit of the time  
5 □ Most of the time  
6 □ All of the time