THE MIGRAINE DISABILITY ASSESSMENT TEST

*Patient Name:*_____ *Date of Birth:*_____ *Date:*_____

The MIDAS (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS

Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your health care professional.

1	On how many days in the last 3 months did you miss work or school because of your headaches?	_____ days
2	On how many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)	_____ days
3	On how many days in the last 3 months did you not do household work because of your headaches?	_____ days
4	On how many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)	_____ days
5	On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?	_____ days
	TOTAL	____ days

MIDAS Scoring. Total the number of days in questions 1-5:

0-5	*Little or No Disability*	*11-20*	*Moderate Disability*
6-10	*Mild Disability*	*21+*	*Severe Disability*

If your MIDAS score is 6 or more, please discuss this with your doctor.

WHAT YOUR PHYSICIAN WILL NEED TO KNOW ABOUT YOUR HEADACHE:

On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day)	_____ days
A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.)	_____ days
B. On a scale of 0-10, on average how painful were these headaches? (If a headache lasted more than 1 day, count each da	_____