



Data Collection Worksheet

Please Note: The Data Collection Worksheet (DCW) is a tool to aid integration of a PhenX protocol into a study. The PhenX DCW is not designed to be a data collection instrument. Investigators will need to decide the best way to collect data for the PhenX protocol in their study. Variables captured in the DCW, along with variable names and unique PhenX variable identifiers, are included in the PhenX Data Dictionary (DD) files.

1. Over the past year, have you suffered from severe headaches?

1 Yes

2 No

If Yes, go to question 2.

If No, questionnaire is complete.

2a. Age:

_____ (Write In Age)

2b. Sex

1 Male

2 Female

3. When you have a severe headache, do you experience any of the following? (**X ALL That Apply**)

1 Nausea

2 Vomiting

3 One side of head only

4 Pulsating/throbbing headaches

5 Pain-free intervals of days or weeks between severe headache attacks

6 Sensitivity to light

7 Sensitivity to noise

8 Blurring of vision

9 Seeing shimmering lights, circles, other shapes, or colors before the eyes, before the headache starts

10 Numbness of lips, tongue, fingers, or legs before the headache starts

4. About how often do your severe headaches occur? **(Write In Number Of Headache Days You Have Per Week Or Month Or Year)**

_____# in a week, OR

_____# in a month, OR

_____# in a year

5. Which statement best describes the pain of your severe headaches? **(X ONE)**

1 Extremely severe pain

2 Severe pain

3 Moderately severe pain

4 Mild pain

6. Which best describes how you are usually affected by severe headaches? **(X ONE)**

1 Able to work/function normally

2 Working ability or activity impaired to some degree

3 Working ability or activity severely impaired

4 Bed rest required

7. Each time you have a severe headache, how long are you unable to work or undertake normal activities? **(X ONE)**

1 0 days (no activity restriction)

2 Less than 1 day

3 1-2 days

4 3-5 days

5 6 or more days

8. On how many days in the last 3 months did you have a headache (if headache lasted more than 1 day, count each day)?

_____ (Write In # Days)

9. Because of your headaches on how many days in the last 3 months . . . ?

a. did you miss work or school

_____ (Write In # Days)

b. was your productivity at work/school reduced by half or more (not including days missed in qu. 9a above)

_____ (Write In # Days)

c. did you not do household work

_____ (Write In # Days)

d. was your productivity in house-hold work reduced by half or more (not including days counted in qu. 9c above)

_____ (Write In # Days)

e. did you miss family, social, or leisure activities

_____ (Write In # Days)

10. At what age did you **BEGIN** having severe headaches?

_____ (Write In Age)

11. Have you ever gone to the hospital emergency room or to an urgent care clinic because of your severe headaches?

1 [] Yes

2 [] No

12. Which best describes the way you usually treat severe headaches? (X ONE)

1 [] Take non-prescription medications

2 [] Take prescription medications

3 [] Take both prescription and non-prescription medications

4 [] Take no medications

13. Have you ever taken prescription medication for headache on a DAILY basis, whether or not you have a headache, to help prevent a severe headache from happening in the first place?

1 Yes

2 No

14. Are you currently taking any other medication on a DAILY basis? (X ALL That Apply)

1 Water pill or prescription diuretic for high blood pressure

2 Prescription medicine (other than water pill) for high blood pressure

3 Prescription medicine for seizures, epilepsy, or fits

4 Prescription medicine for diabetes

5 Prescription medicine for cholesterol

6 Prescription medicine for depression or anxiety

15. When did you last take prescription medication for headache on a DAILY basis to help prevent a severe headache from happening in the first place? (X ONE)

1 Currently taking

2 Last took within the past 3 months

3 Last took 3 to 12 months ago

4 Last took more than 12 months ago

5 Never took

16. Do you consider your severe headaches to be migraines?

1 Yes

2 No

17. Have you ever been diagnosed by a physician or other health professional as suffering from . . . ? (X ALL That Apply)

1 Tension headaches

2 Sinus headaches

3 Cluster headaches

4 Stress headaches

5 "Sick" headaches

6 Migraine headaches

18. If diagnosed with migraines, at what age were you FIRST DIAGNOSED with migraines?

_____ (Write In Age)

19. Height?

_____ (Write In) Feet

_____ (Write In) Inches

20. Current weight?

_____ (Write In Pounds)

Scoring Instructions

In Lipton et al. (2001), respondents were classified as suffering from migraine if they fulfill the criteria for migraine with aura and migraine without aura established in 1998 by the International Headache Society (IHS) (Headache Classification Committee of the International Headache Society, 1998). This included one or more severe headache in the last year with "unilateral or pulsatile pain, and either nausea, vomiting, or phonophobia with photophobia; or visual or sensory aura before the headache" (Lipton et al., 2001). These criteria were updated by the International Headache Society in 2004 (Headache Classification Subcommittee of the International Headache Society, 2004).

Protocol source: <https://www.phenxtoolkit.org/protocols/view/130501>