Migraine Questionnaire used in the SSAGA-1 "Older Cohort" (5999 twins):

I'd now like to ask you some questions about migraine or attacks of headaches.

O1 Have you ever had migraines or attacks of headaches?

No..(GO TO N).....1
Yes.(GO TO O1.A)..5

O1.A Associated with your headaches, have you ever had recurrent attacks of any of the following?

	NO	YES
1. stomach or intestinal pain/dysfunction	1	5
2. nausea, vomiting or diarrhoea	1	5
3. visual problems such as blurring, showers of light blind spots, or double vision	1	5

O1.B How much does it impair your daily activities?

1. not at all.....1
2. interfers with social life.....2
3. must stay from home from work or school.....3
4. must remain in a dark room (i.e, go to bed).....4

O1.C Would you describe the headache pain you usually experience as:

	NO	YES
1. throbbing, pulsating	1	5
2. steady	1	5
3. squeezing, pressing or tightening	1	5

O1.D Do the headaches <u>usually</u> occur on one side of the head?

1. no.....1
2. left.....2
3. right.....3
4. either.....4

O1.E Associated with your headaches, do you experience enhanced sensitivity to

	NO	YES
1. light	1	5
2. sound	1	5
3. noise	1	5