Migraine Questionnaire used in the Twin89 “Younger Cohort” (6265 twins):

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

S1 Have you ever had migraine or recurrent attacks of headaches?

NO........ (GO TO SECTION T)........... 1
YES..................(ASK A)................. 5

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

(CODE FOR EACH)

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<tr>
<td>NO</td>
<td>................................. 1 5</td>
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<tr>
<td>YES</td>
<td>................................. 5</td>
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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

B. Would you describe the pain associated with your headaches as mild, moderate or severe?

MILD ....................... ............................ 1
MODERATE ........... ............................ 5
SEVERE .................. ............................ 6

C. How much do your headaches impair your daily activities? Would you say...

(CIRCLE ONE)

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

D. Would you describe the headache pain you usually experience as:

(CODE FOR EACH)

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1. throbbing, pulsating or pounding - like being stabbed with a sharp knife ............................................................. 1 5
2. pressing - like a weight pushing down on your head ....................................... 1 5
3. squeezing - like a tight band around your head ................................................ 1 5

E. Do the headaches usually occur on one side of the head?

(CIRCLE ONE)

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

F. Associated with your headaches, do you experience enhanced sensitivity to:

(CODE FOR EACH)

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</table>

1. light................................................................................................................... 1 5
2. smell - such as perfume, petrol or smoke ......................................................... 1 5
3. noise.................................................................................................................. 1 5

G. Do your (migraines/episodes of headache) occur in an attack-like manner or are they continuous?

ATTACK-LIKE ....................... 1
CONTINUOUS ...... .................... 5
H. How old were you the first/last time you had (migraine/episodes of headache)?

AGG ONS: __/___

AGG REC: __/___

REC: 0 1 2 3 4 5

I. How many (migraine/episodes of headache) have you had during your lifetime? Would you say: 1-4, 5-10 or 11 or more?

1-4 ................................................. 1
5-10 ................................................. 5
11 or more ................................. 6

J. On average, how long (does/did) a typical (migraine/headache) episode last?

___/___  ___/___
HOURS  MINUTES

(A-J)

K. On average, how often (do/did) you have (migraine/episodes of headache)? A: every day, B: 5-6 days per week, C: 3-4 days per week, D: 2 days per week, E: 1 day per week, F: 2-3 days per month, G: 1 day per month, H: 3-11 days per year, I: less often, J: never.