Study 2 – Migraine Diary

The following is a part of a continuing study between the University of Nevada, Reno, and the University of Utah on the relationship between your sensory experience and migraine headaches.
Please complete this questionnaire if you are adding your daily entries for the diary. This should take approximately 15 minutes to complete. Please try to complete this questionnaire at roughly the same time each day. Thank you for your continued participation.
If you have any questions or comments, please email shaigh@unr.edu. To continue, please enter your login ID. This was the ID provided to you (likely via email) when you first signed up for the study. Make sure to enter your ID in correctly so that we can provide the accurate reimbursement for your participation

Login ID

_____

You will be asked some questions about your sensory experience TODAY.

First, you will be asked questions that are designed to assess your visual experience. Please answer the following questions, thinking about how you were feeling today.
(Conlon, E. G., Lovegrove, W. J., Chekaluk, E., & Pattison, P. E. (1999). Measuring visual discomfort. *Visual Cognition*, *6*(6), 637–663.)

Did your eyes feel watery, red, sore, strained, tired, dry or gritty, after you had been reading a newspaper or magazine with clear print?

- ○ I didn't read today
- ○ No
- ○ A little
- ○ Somewhat
- ○ Yes

Did you get a headache after reading?

- ○ No
- ○ Yes

When reading, did you find yourself unintentionally rereading the same word or the same line of text?

- ○ No
- ○ Occasionally
- ○ Yes

Did you use a pencil or your finger to keep from losing your place when reading a page of text in a novel or magazine?

- ○ No
- ○ Occasionally
- ○ Yes

Did you have to squint to keep the words on a page of clear text from going blurry or out of focus?

- ○ No
- ○ Occasionally
- ○ Yes

Did you find that the words on a page of clear text appeared to fade into the background then reappear?

- ○ Yes
- ○ Occasionally
- ○ No

Did the letters on a page of clear text go blurry when you are reading?

- ○ Yes
- ○ Occasionally
- ○ No

Did the letters on a page appear as a double image when you are reading?

- ○ Yes
- ○ Occasionally
- ○ No

Did the words on the page begin to move or float?

- ○ Yes
- ○ Occasionally
- ○ No

Did you have difficulty keeping the words on the page of clear text in focus?

- ○ Yes
- ○ Occasionally
- ○ No

When you read a page that consisted of black print on white letters, did the background appear to overtake the letters making them hard to read?

- ○ Yes
- ○ Occasionally
- ○ No

When you read a page that consisted of black print on white letters, did you have to move the page around, or continually blink to avoid glare which seemed to come from the background?

- ○ Yes
- ○ Occasionally
- ○ No

Did you have difficulty seeing more than one or two words on a line in focus?

- ○ Yes
- ○ Occasionally
- ○ No

Did you have difficulty reading the words on a page because they began to flicker or shimmer?

- ○ Yes
- ○ Occasionally
- ○ No

(Cortez, M. M., Digre, K., Uddin, D., Hung, M., Blitzer, A., Bounsanga, J., … Katz, B. J. (2019). Validation of a photophobia symptom impact scale. *Cephalalgia*, *39*(11), 1445–1454.)

Did you find it difficult to work under fluorescent lights today?

- ○ I didn't work under fluorescent lights today
- ○ No
- ○ A little
- ○ Somewhat
- ○ Yes

Did you get a headache after working under fluorescent lights?

- ○ No
- ○ Yes

Did your eyes feel watery, red, sore, strained, tired, dry or gritty, when you worked under fluorescent lights?

- ○ No
- ○ A little
- ○ Somewhat
- ○ Yes

Did you find it difficult to look at a computer screen today?

- ○ I didn't look at a computer screen today
- ○ No
- ○ A little
- ○ Somewhat
- ○ Yes

Did you find it difficult to look at a television screen today?

- ○ I didn't look at a television screen today?
- ○ No
- ○ A little
- ○ Somewhat
- ○ Yes

Did sunlight bother you today?

- ○ I didn't go outside / there was very little sun today
- ○ No
- ○ A little
- ○ Somewhat
- ○ Yes

Did the sunlight from going from inside to outside bother you today?

- ○ No
- ○ A little
- ○ Somewhat
- ○ Yes

Did light bother you when driving today?

- ○ I didn't drive today
- ○ No
- ○ A little
- ○ Somewhat
- ○ Yes

Did you wear sunglasses today to deal with your light sensitivity?

- ○ Yes
- ○ No

Where did you wear sunglasses?

- ○ Indoors
- ○ Outdoors
- ○ Both

These questions are designed to assess your auditory experience. Please answer the following questions, thinking about how you were feeling today (within the last 24 hours).
(Khalfa, S., Dubal, S., Veuillet, E., Perez-Diaz, F., Jouvent, R., & Collet, L. (2002). Psychometric normalization of a hyperacusis questionnaire. *Orl*, *64*(6), 436–442.)

Did noise and certain sounds cause you stress and irritation today more than usual?

- ○ No
- ○ A little
- ○ Yes, quite a lot
- ○ Yes, a lot

Did noise and certain sounds impact your ability to concentrate today more than usual?

- ○ No
- ○ A little
- ○ Yes, quite a lot
- ○ Yes, a lot

Did you find it harder to listen to conversation today more than usual?

- ○ No
- ○ A little
- ○ Yes, quite a lot
- ○ Yes, a lot
- ○ I didn't have a conversation today

Did you find it harder to understand what was being said on the telephone today more than usual?

- ○ No
- ○ A little
- ○ Yes, quite a lot
- ○ Yes, a lot
- ○ I didn't use the telephone today

Did street noise bother you today more than usual?

- ○ No
- ○ A little
- ○ Yes, quite a lot
- ○ Yes, a lot
- ○ I wasn't on the street today

Did you have difficulty reading in a noisy situation today more than usual?

- ○ No
- ○ A little
- ○ Yes, quite a lot
- ○ Yes, a lot
- ○ I didn't read today

Did you find it difficult to pay attention when people were talking to you today more than usual?

- ○ No
- ○ A little
- ○ Yes, quite a lot
- ○ Yes, a lot
- ○ I didn't talk to anyone today

These questions are designed to assess your tactile experience. Please answer the following questions, thinking about how you were feeling today.
(Lipton, R. B., Bigal, M. E., Ashina, S., Burstein, R., Silberstein, S., Reed, M. L., … Group, A. M. P. P. A. (2008). Cutaneous allodynia in the migraine population. *Annals of Neurology*, *63*(2), 148–158.)

Did you experience increased pain or unpleasant sensation on your skin today when engaging in any of the following? Select as many as needed.

- [ ] Combing your hair
- [ ] Pulling your hair back (e.g. ponytail)
- [ ] Shaving your face
- [ ] Wearing eyeglasses
- [ ] Wearing contact lenses
- [ ] Wearing earrings
- [ ] Wearing a necklace
- [ ] Wearing tight clothing
- [ ] Taking a shower (when shower water hits your face)
- [ ] Resting your face or head on a pillow
- [ ] Exposure to heat (e.g. cooking, washing your face with hot water)
- [ ] Exposure to cold (e.g. using an ice pack, washing your face with cold water)
- [ ] None of the above

These questions are designed to assess your odor experience. Please answer the following questions, thinking about how you were feeling today.

(Bailer, J., Rist, F., Witthöft, M., & Paul, C. (2004). Validation of a screening instrument for multiple chemical sensitivity (MCS): The Chemical Odor Sensitivity Scale (COSS). *Psychotherapie, Psychosomatik, Medizinische Psychologie*, *54*(11), 396–404.

Bailer, J., Witthöft, M., & Rist, F. (2006). The Chemical Odor Sensitivity Scale: reliability and validity of a screening instrument for idiopathic environmental intolerance. *Journal of Psychosomatic Research*, *61*(1), 71–79.)

Were you exposed to any strong smells today (e.g. perfume, smoke, petrol, gas exhaust)

- ○ Yes
- ○ No

Did the smell make you feel ill?

- ○ No
- ○ A little
- ○ Yes

Did the smell make you feel dizzy?

- ○ No
- ○ A little
- ○ Yes

Did the smell make it feel difficult to breath?

- ○ No
- ○ A little
- ○ Yes

Did the smell make you cough?

- ○ Yes
- ○ A little
- ○ No

Did the smell make you want to leave the room?

- ○ No
- ○ A little
- ○ Yes

These questions are designed to assess motion sickness. Sickness here means feeling queasy or nauseated or actually vomiting. Please answer the following questions, thinking about how you were feeling today.

(Golding, J. F. (1998). Motion sickness susceptibility questionnaire revised and its relationship to other forms of sickness. *Brain Research Bulletin*, *47*(5), 507–516.

Jeong, S.-H., Oh, S.-Y., Kim, H.-J., Koo, J.-W., & Kim, J. S. (2010). Vestibular dysfunction in migraine: effects of associated vertigo and motion sickness. *Journal of Neurology*, *257*(6), 905–912.)

Did you feel motion sick today?

- ○ Yes
- ○ No

What caused you to feel motion sick?

_____

On a scale of 1 to 10, how sick or nauseated did you feel? Please adjust the slider.

	Not sick / nauseated Very sick / nauseated 0 1 2 3 4 5 6 7 8 9 10
Sick / nauseated	

Did you vomit?

- ○ Yes
- ○ No

Next are a couple of questions about any headaches you experienced today. If you did not have a headache then these questions can be skipped.
(Headache Classification Committee of the International Headache Society (IHS) The International Classification of Headache Disorders, 3rd edition. (2018). *Cephalalgia*, *38*(1), 1–211. https://doi.org/10.1177/0333102417738202)

Did you have a headache today?

- ○ Yes
- ○ No
- ○ I'm having one now

How long did it last?

_____

How long ago did it start?

_____

Is / was the pain on one or both sides of the head?

- ○ One
- ○ Both

Which side?

- ○ Left
- ○ Right

On a scale of -10, on average, how painful is / was this headache?

	No pain				Hurts, but is bearable				As bad as it can be	
	0	1	2	3	4	5	6	7	8	9	10
Rate the headache pain											

If you had to describe the headache pain, is / was it... (select any that apply)

- ☐ Throbbing
- ☐ Pulsating
- ☐ Pounding
- ☐ Burning / Pressing
- ☐ Steady
- ☐ Sharp
- ☐ Tight
- ☐ Dull
- ☐ Ache

During your headache, did you have, or are you experiencing... (select any that apply)

- [ ] Nausea / Vomiting
- [ ] Tears in only eye
- [ ] Eyelid drop
- [ ] Facial sweating
- [ ] Nasal congestion

During your headache, were you or are you currently very sensitive to... (select any that apply)

- [ ] Light
- [ ] Noise
- [ ] Strong smells
- [ ] Light touches on the face, arm, or leg

Do you notice any changes in your headache in response to physical activity (e.g. walking up stairs)?

- ○ Yes
- ○ No

Does your head pain get...

- ○ Better
- ○ Same
- ○ Worse

Before or during your headache, did you notice or are you experiencing any changes in your... (select all the apply)

- ☐ Vision
- ☐ Hearing
- ☐ Pins and needles
- ☐ Difficulties with speech or balance
- ☐ No I did not

Can you describe this sensation?

_____

_____

_____

_____

_____

Thank you for your time.