**Investigation of frequency-specific loudness discomfort levels in listeners with migraine questionnaire**

1. Are you 18 years old or older? (Notice: this study is targeted towards participants over 18, if you are less than 18 years old, thank you for your interest but you are not eligible for this study)

* Yes
* No

1. Have you ever been diagnosed with or experience any form of hearing loss? (Notice: This study is targeted towards participants with no prior diagnosis or experience of hearing loss, if you are experiencing hearing loss thank you for your interest but you are not eligible for this study)

* Yes, I have been diagnosed with or I am experiencing hearing loss.
* No, I have not been diagnosed with and I am not experiencing hearing loss.

1. For participants with migraines only: We would like to invite you to take this test twice, once during a migraine or aura and once in the migraine free interval (the order is not important). If you wish to complete the test twice, please write your email in the box below. This is to enable us to match your responses if you choose to take this test twice. We will not email you or share this information. For more information about the way this study will handle your data, please review the participant information sheet.

Enter your email in the box below (please make sure you write down the same email both times):

1. Please select your age group:

* 18-24
* 25-44
* 45-64
* 65+
* I do not wish to answer this question

1. Please select your sex:

* Female
* Male
* Other/I do not wish to answer this question

1. Is this the first time you are completing this study?

* Yes
* No

1. Have you ever been diagnosed with or experience any form of migraine?

* Yes, I have been diagnosed with or I am experiencing migraines.
* No, I have not been diagnosed with and I am not experiencing migraines.

1. Have you ever received a medical diagnosis for your migraines?

* Yes
* No

1. Do you receive any medication for your migraine (prophylactic or on symptomatic)?

* Yes
* No

1. Please write down the name of the medication you are receiving in the box below. (If not available please write "N/A")
2. You have reported experiencing and/or being diagnosed with migraines. Does the following statement apply to you? Sounds that others believe are moderately loud are too loud to me.

* Yes
* No

1. How long have you noticed this phenomenon?

* Days
* Months
* Years

1. Which ear(s) seems to be affected by this phenomenon:

* Left ear
* Right ear
* Both ears

1. Does this phenomenon appear to coincide with your migraines?

* Yes
* No

1. When does this phenomenon occur (select all that apply)

* Before a migraine
* During a migraine
* After a migraine

1. Which of the following sounds or events are often too loud for you (select all that apply)?

* Baby crying/children squealing
* Crowds/large gatherings
* Dishes being stacked
* Dog barking
* High pitch voices/screaming
* Music
* Power tools
* Restaurants
* Sporting events
* Telephone ringing
* TV/radio
* Vacuum cleaner
* Whistle/horn/siren
* None of the above

1. How often do you experience migraines?
2. Are you experiencing a migraine or an aura (sensory disturbance that happen shortly before a migraine) right now?

* Yes, I am experiencing a migraine right now
* Yes, I am experiencing an aura right now
* No, I am not experiencing a migraine or an aura right now