Appendix 1. Questionnaire for the change of headache and life style during the COVID-19

Age: (y), Birth date:
Sex: ☐ Male ☐ Female

• Do you have any other illnesses besides migraine?
☐ Yes ☐ No (disease name:)

• Habits
(1) Do you drink any caffeinated beverages (coffee, tea, Japanese tea, etc.)?
☐ No
☐ Yes. Drink ( ) cups per day

(2) Do you drink alcoholic beverages?
☐ Never
☐ < 1 day/week
☐ 1-2 days/week
☐ 3-5 days/week
☐ 6-7 days/week

(3) Do you smoke?
☐ Not at all.
☐ I used to smoke.
☐ I currently smoke.

• Effects of COVID-19 on work or school activity
Choose one of the following three and the relevant content.

(1) Student/ Kindergarten student.
☐ Constant school (school)
☐ Irregular school (school)
☐ Suspension of school (school)
☐ Other ( )

(2) Continuing to work on the front line in case of an emergency.
☐ Medical service related work ☐ Store staff
☐ Shipping work ☐ Other ( )

(3) After declaring a state of emergency, he refrained from going out and is working from home.
☐ Housekeeper ☐ Office worker ☐ Public official
☐ Faculty member ☐ Service industry ☐ Other( )

(4) Other jobs ( )

• Do you have an interest in COVID-19?
☐ 1 None ☐ 2 Very little ☐ 3 Little ☐ 4 Moderate ☐ 5 Strong

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• Do you have any concerns about COVID-19 (including any kind of anxiety or worry related to COVID-19)?
☐ 1 None ☐ 2 Very little ☐ 3 Little ☐ 4 Moderate ☐ 5 Strong

※ Please answer the questions below by comparing the situation after COVID-19.

• Compared to your usual migraine headache, is the frequency or intensity worse?
☐ Yes ☐ No
If yes, answer the following (1) through (6) questions (if your headache has worsened).

(1) Frequency:
Before COVID-19: Average monthly ( ) days → After: Average monthly ( ) days

(2) Strength (between 1-10 points)
Before COVID-19: Average ( ) point → After: Average ( ) point

(3) The duration when you have a headache.
Before COVID-19: Average ( ) minutes/( ) hours/( ) days
→ After: Average ( ) minutes/( ) hours/( ) days

• After the COVID-19, did you have any problems visiting medical facilities (hospitals)?
☐ Yes ☐ No

• Have you ever run out of medicine because of a problem visiting the hospital?
☐ Yes ☐ No

• Is your stress different from before?
☐ Decrease ☐ Unchanging ☐ Increase

• Is your physical activity different from before?
☐ Decrease ☐ Unchanging ☐ Increase

• Has the frequency of acute drugs used for headache attacks changed?
☐ Decrease ☐ Unchanging ☐ Increase

• Has the migraine prevention/maintenance drug (daily medication) been added or changed?
☐ Yes ☐ No

• Check one of the following 7 levels after COVID-19, compared to before COVID-19.
1 point: Much better.
2 points: Much better.
3 points: Very little better.
4 points: Same as before.
5 points: It's getting a little bad.
6 points: It's getting worse.
7 points: Very much worse.
(1) How strong is your headache? Dot.
(2) How are you feeling these days? Dot.
(3) How's your sleep condition? Dot.

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