

**PATIENT REGISTRATION FORM**

Participant ID:

1. REPORTER CONTACT**1.1 Reporter of Enrollment**

- ☐ Obstetric Health Care Provider
☐ Prescribing or Other Health Care Provider (Specify Specialty): _____
☐ Pregnant Patient
☐ Other (e.g. Guardian of Minor/patient requiring Assent/family member) Specify (e.g. Guardian of Minor/patient requiring Assent/family member): _____

1.2 Enrollment Type: ☐ Phone ☐ Mail ☐ Email ☐ Other, specify: _____

Date of Enrollment: month _____ day _____ year _____

Alternate Contact Form Completed? ☐ Yes ☐ No**1.3 Verbal Informed Consent Received:** ☐ Yes ☐ No

Date Received: month _____ day _____ year _____

Patient Age at Consent: _____

Written Informed Consent Received: ☐ Yes ☐ No

Date Received: month _____ day _____ year _____

Patient Age at Consent: _____

Date of Medical Release: month _____ day _____ year _____

2. PREGNANCY INFORMATION2.1 Is the patient currently pregnant? ☐ Yes ☐ No2.2 Inclusion Criteria ☐ Ajovy (Cohort 1) ☐ Group 1 (Cohort 2) ☐ Group 2 (Cohort 3)2.3 Have Prenatal Tests been completed?* ☐ Yes ☐ No ☐ Unknown

*Prenatal Test results will be collected on the Health Care Provider Reported Baseline Data Form

2.4 Type/Frequency of Migraine

- ☐ Episodic Migraine (EM)- less than 15 days per month
☐ Chronic Migraine (CM)-more than 3 months of headaches on 15 or more days/month on average, at least 8 days of migraine
☐ Unknown

2.5 Date of Migraine diagnosis: month _____ day _____ year _____ Unknown: ☐**2.6 Severity of Migraine**☐ Mild ☐ Moderate ☐ Severe ☐ Unknown**2.7 Migraine with Aura?**☐ Yes ☐ No ☐ Unknown