

# Migraine Diary

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Migraine occurrences		
Date:	Time started:	Time ended:
Description:	Intensity of pain:	Location:
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Left side <input type="checkbox"/> Right side <input type="checkbox"/> All over
Symptoms accompanying headache: <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Visual disturbances e.g. auras <input type="checkbox"/> Light sensitivity <input type="checkbox"/> Sound sensitivity <input type="checkbox"/> Sensory sensitivity (e.g. smells) <input type="checkbox"/> Dizziness <input type="checkbox"/> Others:	Potential triggers: <input type="checkbox"/> Lack of sleep <input type="checkbox"/> Stress <input type="checkbox"/> Missed meal <input type="checkbox"/> Alcohol consumption <input type="checkbox"/> Caffeine consumption <input type="checkbox"/> Weather changes <input type="checkbox"/> Hormonal changes (e.g. menstrual cycle) <input type="checkbox"/> Strong smells <input type="checkbox"/> Others:	
Medication taken, time, and dosage:	Relief:	
	<input type="checkbox"/> Complete <input type="checkbox"/> Partial <input type="checkbox"/> None	
Additional notes, observations, and recommendations		