# Migraine Diary

| Name: | Age: | Date: |
|---|---|---|

| Migraine Occurences | | | | |
|---|---|---|---|---|
| **Date** | **Time started** | | **Time ended** | |
| **Description** | **Intensity of pain** | | **Location** | |
| | ☐ | Mild | ☐ | Front |
| | ☐ | Moderate | ☐ | Back |
| | ☐ | Severe | ☐ | Left Side |
| | | | ☐ | Right Side |
| | | | ☐ | All Over |

| Symptoms Accompanying Headache | | Potential Triggers | |
|---|---|---|---|
| ☐ | Nausea | ☐ | Lack of Sleep |
| ☐ | Vomiting | ☐ | Stress |
| ☐ | Visual disturbances e.g. auras | ☐ | Missed Meal |
| ☐ | Light Sensitivity | ☐ | Alcohol Consumption |
| ☐ | Sound Sensitivity | ☐ | Caffeine Consumption |
| ☐ | Sensory Sensitivity (e.g. smells) | ☐ | Weather Changes |

| | | | |
|---|---|---|---|
| ☐ | Dizziness | ☐ | Hormonal Changes (e.g. menstrual cycle) |
| ☐ | Others: | ☐ | Strong Smells |
| | | ☐ | Others: |
| **Medication Taken, Time, and Dosage** | | **Relief** | |
| | | ☐ | **Complete** |
| | | ☐ | **Partial** |
| | | ☐ | **None** |
| **Additional Notes, Observations, and Recommendations** | | | |