

# MigraineDiary

Name: \_\_\_\_\_

	Attack 1	Attack 2	Attack 3	Attack 4	Attack 5
<b>Date of Migraine Attack</b>					
<b>Migraine Start Time</b>					
<b>Duration of Migraine</b>					
<b>Location of Pain</b>					
<b>Severity of Attack</b> (1 = continued normal activities, 2 = stopped some activities, 3 = stopped all activities)					
<b>Description of Pain</b> (pounding, throbbing, aching, stabbing, pulsing, etc.)					
<b>Eyesight affected?</b> Yes / No					
<b>Felt sick?</b> Yes / No					
<b>Actually got sick?</b> Yes / No					
<b>I had to lie down?</b> Yes / No					
<b>Light bothered me?</b> Yes / No					
<b>Noise bothered me?</b> Yes / No					
<b>Stomach ache?</b> Yes / No					
<b>What was I doing when the attack started?</b>					
<b>Actions Taken to Treat the Pain</b>					
<b>Effectiveness of this Method</b>					
<b>Potential Triggers</b> (food, light, drinking, children, medications, etc.)					
<b>General Notes</b> (what I felt during my migraine?)					
<b>Current Sleep Patterns</b>					
<b>Any recent change in diet?</b>					
<b>Amount of Work Missed</b>					
<b>Additional Notes or Questions:</b>					

Reset Form