



migraine diary

This diary has been designed to let you record important information about your migraines to share with your doctor. It allows you to establish characteristics of both your migraines and your current treatment, which you and your doctor can use to manage your migraines. To ensure that the information will be as accurate as possible, answer these questions soon after each migraine. Leave the boxes blank if they do not apply to you. When a scale is provided, enter the number that best reflects your experience.

Pre Visit

Filling out this diary before your doctor visit will establish a profile of your migraines. This will give your doctor a more precise sense of your migraine symptoms, and help to generate a dialogue about your migraine management plan.

It is not necessary, however, to wait until you've completed the diary before seeing your doctor. If you wish to consult with him or her, do so at any time.

Post Visit

Keeping a migraine diary is just as important after you've seen your doctor. So be sure to continue to record information about your migraines and your treatment program following each visit with your doctor. The information you gather will alert your doctor to changes in your migraine patterns, which can be compared to the patterns of your previous treatment program. It is very important to give your doctor critical feedback in order to accurately measure the effects of your treatment.



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Please check the boxes that apply to you for each migraine. Leave the boxes blank if they do not apply to you. When a scale is provided, enter the number that best reflects your experience.

	Migraine 1	Migraine 2	Migraine 3	Migraine 4	Migraine 5	Migraine 6	Migraine 7
Date							
Time began							
Time ended							
Duration							
I. Preceding Symptoms							
a. Visual Disturbances							
Flashing lights							
Flashbulb-like blind spots							
Zigzag lines							
Shimmering lights							
Blurred vision							
Other (<i>specify</i>)							
b. Numbness/Tingling							
Arm(s)							
Face							
Chest							
Leg(s)							
Other (<i>specify</i>)							
c. Other Symptoms							
Mood changes							
Sudden increase in energy							
Food cravings							
Frequent yawning or fatigue							
Diarrhea/constipation							
Speech problems							
Other (<i>specify</i>)							



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Migraine 1	Migraine 2	Migraine 3	Migraine 4	Migraine 5		
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2. Migraine Symptoms

a. Pain Severity Scale

(In each box, enter the number that best describes the severity of your migraine pain)

0	1	2	3						
None	Mild	Moderate	Severe						

b. Description of Pain (Check all that apply for each migraine)

Stabbing

Pressure

Dull ache

Throbbing

Other (specify)

c. Location of Pain (Check all that apply for each migraine)

Left side of head

Right side of head

Front of the head

Back of the head

Behind the eye

All around the head

Other (specify)

d. Other Symptoms Experienced (Check all that apply for each migraine)

Nausea

Sensitivity to light

Vomiting

Sensitivity to sound

Other (specify)

e. Duration of Migraine (Check the appropriate box for each migraine)

Up to 4 hours

4-8 hours

8-24 hours

More than 24 hours



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3. Migraine Triggers *(Check all that apply for each migraine)*

4. Treatment

a. Medication(s)

Name of medication(s)

Amount

Response to treatment

(After taking your medication, what was your pain level?)

0 1 2 3
None Mild Moderate Severe

Does relieve pain adequately						
Doesn't relieve pain adequately						
Does relieve pain long enough						
Doesn't relieve pain long enough						
Does relieve accompanying symptoms						
Doesn't relieve accompanying symptoms						
Does work once migraine has fully begun						
Doesn't work once migraine has fully begun						
Loses effectiveness with repeated use						
Doesn't lose effectiveness with repeated use						
Other						



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If you are experiencing any side effects, list them below and be sure to discuss with your doctor.

b. Non-medical Treatments *(Check those that you have tried for each migraine)*

Inactivity							
Sleep							
Darkness							
Heat							
Cold compresses							
Relaxation techniques							
Biofeedback							
Other <i>(specify)</i>							

Effectiveness Scale

(In each box, enter the number that best reflects the effectiveness of your non-medical treatment)

0 1 2 3
 None Mild Moderate Severe

5. Lifestyle Impact

a. Everyday Activities *(Check one for each migraine)*

Cannot perform most or any							
Perform, but impaired							
No impairment							

b. Work Missed

# Hours / # Days							
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c. Work Activities (Check one for each migraine)

Cannot perform most or any						
Perform, but impaired						
No impairment						

d. Support

Response of family and coworkers *(Please describe)*