MIGRAINE DIARY

This diary has been designed to let you record important information about your migraines both before and after you see your doctor. It allows you to establish characteristics of both your migraines and your current treatment, which you and your doctor can use for later comparison. To ensure that the information will be as accurate as possible, answer these questions as soon after each migraine as you can. Leave the boxes blank if they do not apply to you. When a scale is provided, enter the number from 1 to 5 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 the effectiveness of your current treatment. From this, he or she may be able to recommend a more effective treatment program.

It is not necessary, however, to wait until you have charted three Pre Visit migraines 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 in the Post Visit columns. 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. This will give your doctor critical feedback and a way to measure whether your treatment program is the most effective one for you.

MIGRAINE DIARY

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 from 1 to 5 that best reflects your experience.

	PRE VISIT			POST VISIT	
	Migraine No.1	Migraine No.2	Migraine No.3	Migraine No.1	Migraine No.2
Date ►					
Time began ►					
Time ended ►					
Duration ►					
1. Preceding Symptoms					
A) VISUAL DISTURBANCES OR AURA					
Flashing lights					
Flashbulb-like blind spots					
Zigzag lines					
Shimmering lights					
Blurred vision					
Other *(specify)*					
B) MOTOR DISTURBANCES					
Loss of balance					
Slurred speech					
Other *(specify)*					
C) NUMBNESS/TINGLING					
Arm(s)					
Face					
Chest					
Leg(s)					
Other *(specify)*					
D) OTHER SYMPTOMS					
Mood changes					
Sudden increase in energy					
Food cravings					
Frequent yawning or fatigue					
Diarrhea/constipation					
Other *(specify)*					

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MIGRAINE DIARY

	PRE VISIT			POST VISIT	
	Migraine No.1	Migraine No.2	Migraine No.3	Migraine No.1	Migraine No.2
2.Migraine Symptoms					
A) PAIN SEVERITY SCALE *(In each box, enter the number that best describes the severity of your migraine)* 1 2 3 4 5 (not severe … most severe)					
B) DESCRIPTION OF PAIN *(Check those that apply for each migraine)*					
Throbbing					
Stabbing					
Pounding					
Dull ache					
Pulsating					
Other *(specify)*					
C) LOCATION OF PAIN *(Check those that apply for each migraine)*					
Left side of head					
Right side of head					
Both sides of head					
Front of head					
Back of head					
Behind the eye					
All around the head					
Other *(specify)*					
D) OTHER SYMPTOMS EXPERIENCED *(Check those that apply for each migraine)*					
Nausea					
Sensitivity					
Vomiting					
Sensitivity to light and sound					
Other *(specify)*					
E) DURATION OF MIGRAINE *(Check the appropriate box for each migraine)*					
2 - 4 hours					
4 - 8 hours					
8 - 24 hours					
More than 24 hours					

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	PRE VISIT			POST VISIT	
	Migraine No.1	Migraine No.2	Migraine No.3	Migraine No.1	Migraine No.2
3. Treatment					
A) MEDICATION(S)					
What taken					
Amount					
Effectiveness Scale *(In each box, enter the number that best reflects the effectiveness of your relief)* 1 2 3 4 5 not effective — most effective					
Which of these specific problems apply to your medication? *(Check appropriate box for each migraine)*					
Doesn't relieve pain adequately					
Doesn't relieve pain long enough					
Doesn't relieve accompanying symptoms					
Doesn't work once migraine has fully begun					
Causes drowsiness					
Loses effectiveness with repeated use					
Other					
How severe are the side effects of your medication? *(In each box, enter the number that best reflects the overall severity of these side effects)* 1 2 3 4 5 not severe — most severe					

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MIGRAINE DIARY

	PRE VISIT			POST VISIT	
	Migraine No.1	Migraine No.2	Migraine No.3	Migraine No.1	Migraine No.2
B) NONMEDICAL TREATMENTS *(Check those that you have tried for each migraine)*					
Inactivity					
Sleep					
Darkness					
Heat					
Cold compresses					
Ice					
Relaxation techniques					
Biofeedback					
Other *(specify)*					
Effectiveness Scale *(In each box, enter the number that best reflects the overall effectiveness of your nonmedical treatment)* 1 2 3 4 5 not effective most effective					

4. 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					

C) WORK INTERFERENCE

Response of coworkers: *(Write in all that apply: Understanding, Angry, Skeptical, Frustrated)*

D) FAMILY LIFE INTERFERENCE

Response of family: *(Write in all that apply: Understanding, Angry, Skeptical, Frustrated)*