PATIENT EDUCATION

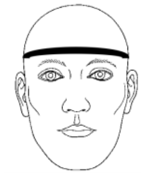
# MIGRAINE DIARY

DATE____________________

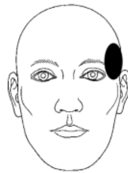
| TIME | | | | | |
|---|---|---|---|---|---|
| | When did it start? | How long did it last? | | When did it start? | How long did it last? |
| 1. | | | 3. | | |
| 2. | | | 4. | | |

## LOCATION

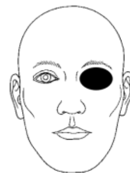
Use the numbers above to place in the box below where your headache was located. (Ex. Headache 1 was a tension headache)



Tension



GCA
Giant Cell Arteries



Cluster

Sinus

Migraine

Neck

## PAIN TYPE

☐ Pressure ☐ Squeezing ☐ Band-like ☐ Pulsing/Pounding ☐ Throbbing ☐ Stabbing

## SEVERITY

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|

## IDENTIFIED POSSIBLE TRIGGER FOR THIS HEADACHE

| | | | | |
|---|---|---|---|---|
| ☐ Caffeine | ☐ Lack of Sleep | ☐ Eye Strain | ☐ Smell/Scent | ☐ Allergies |
| ☐ Alcohol | ☐ Stress | ☐ Sickness | ☐ Skipped Meal | ☐ Noise |
| ☐ Medication | ☐ Bright Light | ☐ Travel | ☐ Weather Change | ☐ Anxiety |
| ☐ Food________ | ☐ PC/TV Screen | ☐ Motion | ☐ PMS | ☐ Reading |
| ☐ Woke up with new onset | ☐ Current Menstrual Cycle/On Period | ☐ Date of Last Menstrual Cycle _____________ | ☐ Other_____________ | ☐ ___________ |

## RELIEF MEASURES

| | | |
|---|---|---|
| ☐ Prescription Migraine Medication | ☐ Over the Counter________ | ☐ Exercise |
| ☐ Sleep/Rest | ☐ Ibuprofen, Excedrin, Tylenol | ☐ Other |

## ASSOCIATED SYMPTOMS

| | | |
|---|---|---|
| ☐ Light | ☐ Speech/Language Difficulty | ☐ Activity Intolerance |
| ☐ Sound | ☐ Numbness/Tingling Face/Arm/Leg | ☐ Nausea |
| ☐ Smell | ☐ Weakness | ☐ Vomiting |
| ☐ Visual Aura | ☐ Focusing Problems | ☐ Diarrhea |
| ☐ Fatigue/Irritability | ☐ ________________________________ | ☐ ________________ |