Detailed Migraine Diary

Name _____ Month/Date _____

Part 1: Headache severity (0= no pain, 10 = highest pain level)

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Morning																															
Afternoon																															
Evening																															

Part 2: Headache duration

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Time headache began																															
Time headache ended																															
Total hours																															

Part 3: Headache symptoms (Please check all that apply)

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aura																															
Nausea																															
Sensitivity to light																															
Sensitivity to sound																															
Inability to work/function																															
Throbbing																															

Part 4: Please list the name and dose of medication used

_____

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Please fax to 410-730-2812 (Attn: Jill) as soon as the month is completed. If you have any questions, please call 410-730-1212.

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