

Migraine Diary

Track & Manage your Migraines, Before they Manage You!

A migraine diary is a tool for managing your migraines by tracking your symptoms and recording important facts about your migraines – before, during, and after they occur. The diary can help you identify potential triggers and monitor the effectiveness of treatments. The data you generate can also help your doctor correctly diagnose migraine or other disorders. If you are starting MigreLief triple therapy, be sure to note any differences in frequency and intensity of your migraines as well as the reduction in use of prescription and OTC medications. Continue to record in the diary for each migraine experienced.

My migraine began:

Date: (mm/dd/yyyy) ___/___/___

Time: ___:___ AM PM

My migraine ended:

Date: (mm/dd/yyyy) ___/___/___

Time: ___:___ AM PM

Symptoms before my headache:

Visual disturbances or aura? Yes No

Motor disturbances? Yes No

Numbness/tingling? Yes No

Other _____

My headache symptoms:

Numbness/tingling? Yes No

Pain intensity: 1 2 3 4 5
(1= less intense 5= more intense)

Description of Pain: _____
(eg. throbbing, stabbing, pounding, dull ache, pulsating)

Location of pain: (mark with "Xs")

Other Symptoms: _____

(eg. nausea, sensitivity to light, vomiting, sensitivity to smells or sound...)

MY MIGRAINE TREATMENT

Medications I took including dosages:

Treatment effectiveness 1 2 3 4 5
(1= not effective 5= most effective)

Time it took for treatment to work:

Nonmedical treatment: _____

(e.g. sleep, heat, cold compresses, dark, massage, other)

Rebound headache: (Migraine returned soon after treatment)

How soon?

Symptoms:

Other: _____

Possible Headache Triggers:

- Changes in sleeping pattern.
 - Changes in eating pattern.
 - Food-Drink
 - Environmental (weather, lights, noises, odor)
 - Activity or exercise
 - Hormonal (menstrual, birth-control, estrogen Supplements)
 - Medication
 - Emotions (stress, anger, depression, fatigue, anxiety)
 - Other _____
- _____

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- Other _____

MIGRAINE HISTORY OVERVIEW

MIGRELIEF START DATE _____

	A		B	C	D	E		F	G	H
	Migraine Time	Date	Intensity (1-10)	Duration	Medications	Treatment Other	Treatment Time	Comments & Triggers		
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
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16										
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18										
19										

For additional migraine information & helpful hints go to www.MigreLief.com and ask our Health Advisor.