My Migraine Diary

My Name: _____ 31-Day Symptom Chart: Staring on _____ to _____

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

Use the following codes to chart your headache pattern and impact:

M = days with migraine (circle if severe)
W = work missed
A = activity missed
T = treatment days

OTC = over-the counter medications used
Rx = prescription medications use
MC = menstrual cycle medication used

Headache symptoms:

N = nausea
V = vomiting
S = sound sensitive
L = light sensitive
PM = pain with movement

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My Migraine Treatments

Date of Headache: _____ / _____ / _____ (1 = mild, 5 = severe) Medication (s): ____________ What time did your headache start? ____________ What time did you take something? ____________ What did you take? What dosage? ____________ ____________ How severe was your headache when you began treatment? 1 2 3 4 5 Describe your headache 30 minutes: 1 2 3 4 5 Did you take anything else? (Rescue) yes no If yes, what did you take and at what time? ____________ ____________ Notes / Questions for my provider: ____________	**Date of Headache:** _____ / _____ / _____ (1 = mild, 5 = severe) Medication (s): ____________ What time did your headache start? ____________ What time did you take something? ____________ What did you take? What dosage? ____________ ____________ How severe was your headache when you began treatment? 1 2 3 4 5 Describe your headache 30 minutes: 1 2 3 4 5 Did you take anything else? (Rescue) yes no If yes, what did you take and at what time? ____________ ____________ Notes / Questions for my provider: ____________
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