MIGRAINE DIARY

ONSET

Date

MONTH DAY YEAR

Began

☐ AM
☐ PM

Ended

☐ AM
☐ PM

Warning Signs

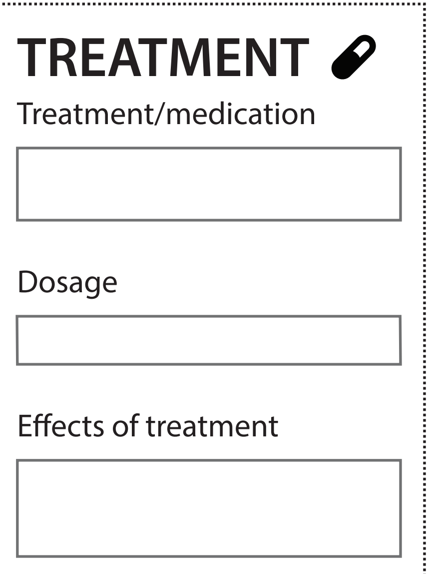
PAIN

Intensity

1 2 3 4 5 6 7 8 9

Type

Location

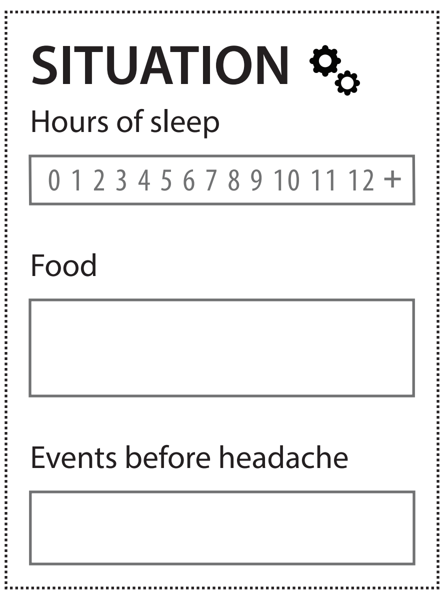


TREATMENT

Treatment/medication

Dosage

Effects of treatment



SITUATION

Hours of sleep

0 1 2 3 4 5 6 7 8 9 10 11 12 +

Food

Events before headache

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