Migraine Log

Name								On Location Note Right (R), Left, (L) or Both (B)					Check Box If Symptom is Present																				
Line Number	Date	Migraine Y(yes) N (no)	Time Began	Time Ends	Total time	Intensity 0 – 10	Medication & Amount	Behind / around Eye	Temple	Above Eyebrows	Back head / Neck	Other Location	Nausea	Vomiting	Diarrhea	Bothered by Light/Noise	Blurred/double Vision	Sparking Lights	Eyelid Puffy	Eyelid Droops	Loss if Vision	Lightheaded	Numbness / Tingling	Weakness Arms/Legs	Difficulty Concentration	Speech difficulty	Loss of Consciousness	Runny Nose	Other
	Example	Y	7:00 AM	9:00 AM	2 hrs	8	Imitrex 2 tab	Start B	2nd rt	0	0	cheeks																	
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Did the following bring on or make migraine worse?															
Line Number	Stress	Bright Sunshine	Weather Change	Letdown After Stress	Loud Noise	Heavy Lifting	Air Travel	Fatigue	Smells or Perfume	Missed Meals	Sexual Activity	Straining or Bending	Certain Foods	Other Notes
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