Name							On Location note Right, Left or Both					The following check Box if apply																	Did the following bring on or make migraine worse?													
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 of Vision	Lightheaded	Numbness/Tingling	Weakness arm/Legs	Difficulty concentration	Speech difficulty	Loss of consciousness	Runny nose	Other	Stress	Bright Sunshine	Weather change	Letdown after stress	Loud noise	Heavy lifting	Air travel	Fatigue	Smells or perfume	Missed Meals	Sexual activity	Straining bending	Certain foods	Other notes
example	Y	7:00 AM	9:00 AM	2 hrs	8	Imitrex 2 tab	3/both/6	1/ right/ 8	2/ right/ 6	0	cheeks																															
Totals																																										

Please identify where the migraine pain begins then where it travels to. Make sure to indicate if the pain is right, left or both sides. If the pain level is different in each site include this as well.