Patient Name _____ Patient DOB _____

MONTH _____

Day	Headache Y/N	Highest Intensity /10	What Abortive Therapy?	Relief (0,1,2, or 3)**	Trigger?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					

Please use dark ink.

0=no relief

1=slight relief

2=moderate relief

3=complete relief

Place an X during menastration.

Migraine Triggers

Use this key to complete the trigger section of the migraine diary

Hormones

1. Menses (period)
2. Ovulation
3. Hormone replacement therapy
4. Oral contraceptives

Diet

5. Alcohol
6. Chocolate
7. Aged cheeses
8. Monosodium glutamate (MSG)
9. Artificial sweeteners
10. Caffeine
11. Nuts
12. Nitrates and Nitrites (found in hot dogs, bologna, and other processed meats)
13. Citrus fruits
14. Other

Sensory stimuli

15. Strong light
16. Flickering light
17. Odors

Changes

18. Weather
19. Seasons
20. Travel (crossing a time zone)
21. Altitude
22. Schedule change
23. Sleeping patterns (erratic or changes in normal patterns)
24. Diet
25. Skipping meals

Stress

26. Let-down periods (vacations, weekends, after a major event)
27. Times of intense activity
28. Loss (death, separation, divorce)
29. Relationship difficulties
30. Job stress, loss, or change
31. Crisis
32. Other