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headache/migraine diary women

name:
date of birth:

Note every day if you suffered from a migraine attack (=1) or not (=0)
For your migraine attacks indicate the severity as 1, 2 or 3
1= a mild attack, does not inhibit work or other activities
2= a medium attack inhibits but does not prohibit work or other activities.
3= a severe attack prohibits word and/ or other activities

Aura: visual = scintillations/flashes/zigzagging lines
sensory = numbness
motor = motor weakness

Dizziness: 1=mild, 2=medium, 3=severe

Month & year:	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
Headache no = 0, yes = 1																															
Severity 1, 2 or 3																															
Visual aura no = 0, yes = 1																															
Sensory aura no = 0, yes = 1																															
Language disorder no = 0, yes = 1																															
Motor aura no=0, yes=1																															
Total duration of the aura (minutes)																															
Headache left = L, right = R, both sides = B																															
Headache throbbing = T, pressing = P																															
Sensitive for light no = 0, yes = 1																															
Sensitive for sounds no = 0, yes = 1																															
Sensitive for smells 0 = no, 1 = yes																															
Nausea = 1, vomiting = 2, no symptoms = 0																															
Start of pain (0-24h)																															
End of pain (0-24h)																															
Dizziness no = 0, yes = 1																															
Severity 1, 2 or 3																															
Number of used painkillers																															
Number of used triptans																															
Imitrex																															
Menstruation? Tick the box																															

Name

Please take this diary with you every consultation or forward it by email