Name						Location where the headaches start from (please identify RIGHT or LEFT)					Symptoms: please check all that apply																	Did the following bring on or make migraine worse? (check all that apply)													
Date	Migraine Y(yes) N (No)	Time Began	Time Ends	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
Totals																																									