



## Migraine diary

On days you have had a migraine attack you can answer the following questions:

Date					
What was happening at about the time you started having the migraine? <small>For example: Did you feel stressed out? Had you gotten enough sleep, or eaten something out of the ordinary?</small>					
When did you have a migraine today?	<input type="radio"/> morning <input type="radio"/> noon <input type="radio"/> afternoon <input type="radio"/> nighttime	<input type="radio"/> morning <input type="radio"/> noon <input type="radio"/> afternoon <input type="radio"/> nighttime	<input type="radio"/> morning <input type="radio"/> noon <input type="radio"/> afternoon <input type="radio"/> nighttime	<input type="radio"/> morning <input type="radio"/> noon <input type="radio"/> afternoon <input type="radio"/> nighttime	<input type="radio"/> morning <input type="radio"/> noon <input type="radio"/> afternoon <input type="radio"/> nighttime
How long did the migraine last?	_____ hours	_____ hours	_____ hours	_____ hours	_____ hours
How severe was the pain?	<input type="radio"/> mild <input type="radio"/> moderate <input type="radio"/> severe	<input type="radio"/> mild <input type="radio"/> moderate <input type="radio"/> severe	<input type="radio"/> mild <input type="radio"/> moderate <input type="radio"/> severe	<input type="radio"/> mild <input type="radio"/> moderate <input type="radio"/> severe	<input type="radio"/> mild <input type="radio"/> moderate <input type="radio"/> severe
Did you take any medication? (If so: what kind and how much)	<input type="radio"/> no <input type="radio"/> yes, type:	<input type="radio"/> no <input type="radio"/> yes, type:	<input type="radio"/> no <input type="radio"/> yes, type:	<input type="radio"/> no <input type="radio"/> yes, type:	<input type="radio"/> no <input type="radio"/> yes, type:

